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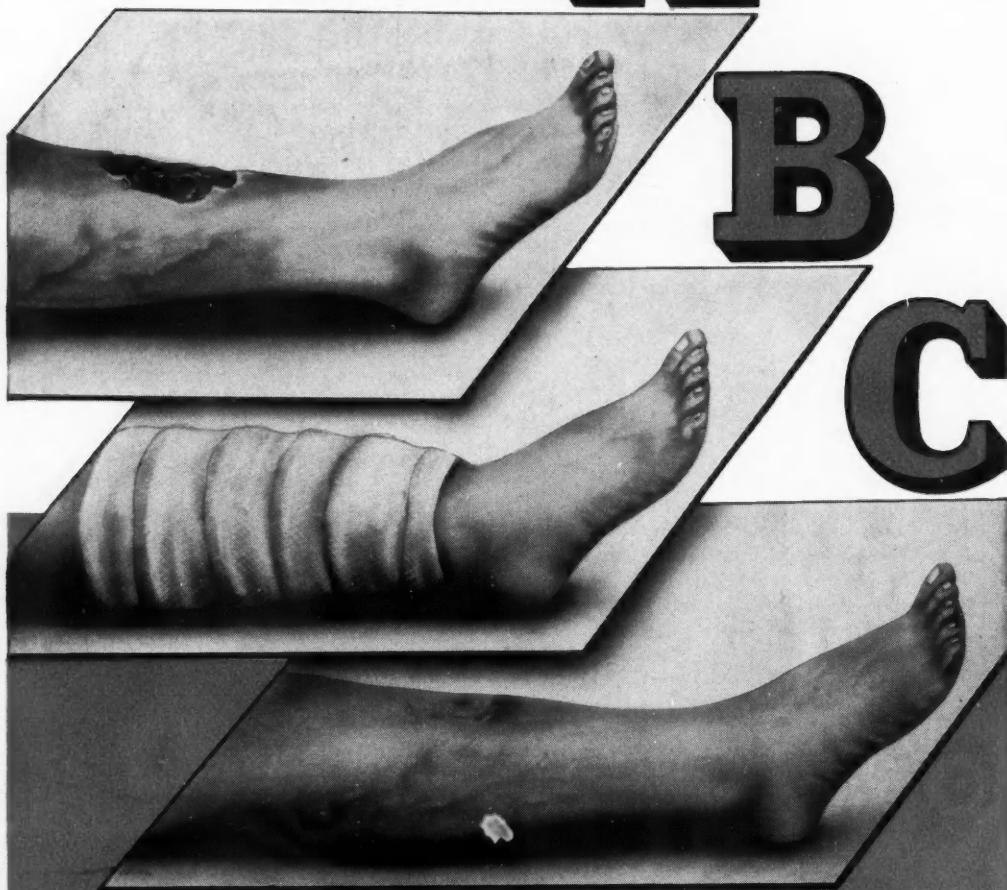
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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)  
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*Leaflet Regarding Rules of Publication.*—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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## EDITORIALS

### INDOCTRINATION COURSE FOR APPLICANTS TO COUNTY MEDICAL SOCIETY MEMBERSHIP—LOS ANGELES COUNTY MEDICAL ASSOCIATION INAUGURATES A CONSTRUCTIVE PLAN

**World Unrest Makes for Social Unrest and Changes.**—In all places and at all times, acute variations in modes of government or living have brought into being new methods of procedure; the changes being designed to create better harmony with conditions that may have undergone rapid and extensive variation.

An example of such a phenomenon may be noted in the different outlook and orientation now almost everywhere held on national and international relationships. These have grown up through observation of the dreadful costs in human suffering and lives, and the vast devastation of material resources that have taken place in both occidental and oriental countries.

For today, it may be said that European and Occidental civilizations are in a state of flux,—in some places more, in others less—but everywhere in sufficient amount to influence the present and future living of millions of human beings.

\* \* \*

**Medical Practice is also Faced with Changes.**—Since such conditions exist, it is not surprising that the healing art profession should now find itself called upon to solve new and difficult problems in medical organization and economics; on matters which, a brief quarter of a century ago, were not given even a passing thought by perhaps eight out of every ten Doctors of Medicine.

The significance of such a state of affairs is this:—That many, perhaps a majority of physicians, who are now being called upon to consider plans that could make great changes in individual and collective medical practice,—do not possess the background of knowledge on medical economics and public relations to enable them to form quick and satisfactory conclusions on proposed methods of practice, that are radically different from those to which they have been accustomed since their undergraduate days.

While many individual physicians have failed to sense the significance of these impending innovations, such have been appreciated, however, by many medical organizations and their administrative officers.

**County Medical Societies Can Lay Foundation for Better Understanding.**—How to lay the foundation for a better understanding by all physicians of the problems now confronting the medical profession has been much discussed during the last two or three decades. Many plans have been proposed but few have been accepted or tried out. Recently, one of the component county medical units of the California Medical Association—that of Los Angeles—has announced and put into operation its "Indoctrination Plan,"—a procedure that is certainly thought-stimulating.

There may be some who would contend that what is being attempted in Los Angeles is an activity more properly a function of every medical school. Perhaps so, but since the medical schools of the United States have given little more than lip service to their responsibilities in this work, it follows that the next line of attack must be, not with the undergraduate student, but with the individual upon whom the M.D. degree has already been bestowed by a medical school.

\* \* \*

**County Medical Societies are Sole Judges of Membership Applicants.**—The question then arises,—What are the ways and means through which Doctors of Medicine may be contacted and put in better harmony with changes now taking place?

The answer is,—Through the County Medical Societies, since practically all physicians do or should aspire for membership in the organizations that are made up of their fellow physicians who have joined together in collective effort; in order better to promote an improvement in the service quality of both scientific medicine and public health activities.

Fortunately, membership in the national and state medical societies may only be secured through prior membership in a component county medical society. The county medical units possess the sole, absolute, and independent authority on who, and under what conditions an applicant physician may be granted membership relations. Since the county medical societies possess these rights, they also have the obligation to demand that all physicians whom they do admit into membership shall have not only proper scientific and ethical qualifications, but also an adequate understanding and outlook on medical organization, economics and public relations. While it is true that individuals contribute much to the advancement of scientific medicine, the end results depend in good part upon the collective or mass work of physicians.

\* \* \*

**What is the "Indoctrination Plan" of the Los Angeles County Medical Association?**—What has been written above, is a sort of prelude to presentation of the significant plan recently instituted by the third largest county medical association in the United States—that of Los Angeles. (For statistics, see page 136.)

The story of the aspirations of that important county unit—exceeded in membership numbers by only 9 constituent state medical societies of the American Medical Association—is best told perhaps in excerpts from editorials and articles that have appeared in *The Bulletin* of the Los Angeles County Medical Association.

It is to be hoped that members will take the time to read these, and to ask themselves whether in their own county medical organizations, somewhat similar plans could not be tried.

The excerpts follow:

\* \* \*

(1) From *The Bulletin* of October 4, 1945:

That every applicant for membership in a component county medical association should be required to attend a course of lectures designed to indoctrinate him thoroughly in certain aspects of the successful practice of medicine, was the substance of a resolution recently adopted by the Council of the California Medical Association. The plan was discussed by the Council of the Los Angeles County Medical Association at its last meeting.

If the program is accepted, every physician who seeks membership will be required to attend and to pass an examination on the subject matter of a series of lectures by qualified instructors in professional ethics, malpractice prophylaxis, laws governing medical practice and narcotics, the state poison act, public health ordinances, and laws governing birth, death and other certificates. The history of our county medical association—its aims, accomplishments and struggles—should be taught to every new member. Each applicant should become familiar with the work of the Physicians' Aid Association and the Medical Milk Commission. He would also derive benefit from information concerning the county hospital, the health department, the coroner's office, workmen's compensation laws and proper conduct as an expert witness.

\* \* \*

(2) From *The Bulletin* of December 20, 1945:

**Indoctrination.**—Each new applicant for membership in the Los Angeles County Medical Association will henceforth be required to attend a course of lectures by qualified instructors, designed to augment his knowledge of California laws affecting the practice of medicine, of malpractice prophylaxis, of professional ethics and courtesy, of the Association's history, accomplishments and aims, and of other essential subjects. This, the so-called "Indoctrination Plan," was discussed more fully on this page in *The Bulletin* of October 4, 1945. The Council, at its meeting on December 3, ordered that the program be instituted forthwith and instructed President J. J. Crane to appoint a committee to outline and supervise the required course of instruction.

The number of lectures to be given, the topics, the lecturers, and the scope of the examination will be determined by the committee. It is believed that this instruction will be of material value, not only to young physicians but to those from outside the State who are unfamiliar with customs and conditions in California. The applicant will also obtain a knowledge of the Association and its activities which should encourage his active participation in its work from the beginning of his career.

This has become increasingly difficult as the number of applicants has increased. Membership in this Association is a valuable and coveted asset. It should be granted only to physicians of high character and ability, whose careers will add to the lustre of that membership. The Association has no need of those whose business methods, habits, or lack of ability have made them failures elsewhere.

(3) From *The Bulletin* of the Los Angeles County Medical Association, issue of February 7, 1946:

A change in the procedure admitting applicants to membership in the Los Angeles County Medical Association was approved by the Council at its December meeting. At that meeting a committee known as a General Committee on Indoctrination was appointed: Dr. Jay J. Crane, Chairman, and Doctor L. A. Alesen, Howard W. Bosworth, E. T. Remmen, and Paul D. Quaintance.

The committee was instructed to develop and to put into effect a program providing for a series of lectures on subjects of importance to all doctors of medicine seeking membership in the Association—attendance of applicants at these lectures being necessary before their applications would be considered by the Council.

The General Committee on Indoctrination, at its first meeting January 14, announced the appointment of the following sub-committees—each sub-committee charged with presenting one of the six lecture courses:

*On Medical Organization*

E. T. Remmen, M.D., Chairman

*On Health Insurance*

Lowell S. Goin, M.D., Chairman

*On Medical Public Relations*

Paul A. Quaintance, M.D., Chairman

*On Medical Ethics*

Donald A. Charnock, M.D., Chairman

*On Medical Education and Medical Economics*

L. A. Alesen, M.D., Chairman

*On Medical Malpractice*

Donald G. Tollefson, M.D., Chairman

These lectures will be presented in the lounge of the Association, beginning promptly at 7:30 o'clock on the 3rd and 4th Friday evenings of each month. The first lecture was presented January 25.

Dr. Regan stated that each chairman of the various sub-committees had assumed the responsibility of preparing a lecture. Following the lecture the applicants will have the privilege of asking questions. Dr. Regan expressed the hope that all members of the sub-committee presenting a subject at a given meeting, would attend that meeting.

Dr. Remmen said that a major objective sought in this program was that members of the committees could become acquainted with the applicants. He recommended that the meetings be so arranged that committee members would have the opportunity to interview the applicants to determine their attitude toward the Association, and to gain further information about their background.

Dr. Crowe moved that the plan as presented by Dr. Regan, including the composition and activities of the various committees, be approved by the General Indoctrination Committee. This motion was seconded and unanimously passed.

**TWO IMPORTANT MEDICAL CONVENTIONS  
IN CALIFORNIA THIS YEAR—C.M.A. AT  
LOS ANGELES, MAY 7-10; A.M.A. IN  
SAN FRANCISCO, JULY 1-5**

**Los Angeles Session Will Transact Important Business.**—Now that VE and VJ days are behind us, California Medical Association will change in this year, 1946, from a two-day and streamlined week-end annual session, to one of four days duration.

Place will be Hotel Biltmore in Los Angeles;

the dates, Tuesday, May 7 through Friday, May 10.

The C.M.A. Committee on Scientific Work and Section Officers have been somewhat handicapped in the preparation of the scientific programs, because many members have been in military service, and the conditions under which civilian physicians have been carrying on their work, have not given much time for research and special studies.

It is hoped, however, to present scientific addresses, papers and panel discussions that will have appeal, and be of up-to-date interest and value. The complete programs will appear in the April issue of CALIFORNIA AND WESTERN MEDICINE.

Much important business will be presented for consideration, to both the House of Delegates of the California Medical Association and Administrative Members of California Physicians' Service.

Social events will not be entirely forgotten. The dinner reception to retiring President Philip K. Gilman will take place in the Biltmore Bowl, where a large attendance of one thousand persons is almost a certainty.

C.M.A. members are requested to make note of the days of the meetings, and to arrange their schedules to permit attendance, if at all possible.

Younger members and physicians who have taken up their residence in California during the last several years are especially urged to attend; to learn for themselves the benefits that may be derived through contacts with fellow physicians, in both scientific and good fellowship conferences.

\* \* \*

**American Medical Session will Follow, in July, at San Francisco.**—The 74th annual session of the American Medical Association was held in San Francisco June 25-29, 1923, and the 94th annual convention, June 13-17, 1938. This year's annual conference of the A.M.A. will convene in San Francisco on Monday, July 1 and carry on through Friday, July 5.

According to A.M.A. custom, the local county medical association—San Francisco County Medical Society—rather than the California Medical Association will be the host of honor; although both organizations will work in close relationship in order to make this San Francisco session a great success.

Dr. John W. Cline was nominated to be chairman of the Committee on Arrangements, and with his associates, he has gotten arrangements in good hand.

Because this is the first opportunity since beginning of World War II, for physicians throughout the United States to meet in annual conference, after the manner of former years, and because many physicians who have been working under stress and strain during the war years need a vacation, there is every indication that the

attendance at the annual A.M.A. session in July will be unusually large.

California physicians who have never attended an annual conference of the national medical organization should not miss this opportunity to be present, to better acquaint themselves with the bigness and broadness of the scientific and organizational activities of the American Medical Association.

**STATE UNIVERSITY MEDICAL SCHOOLS IN SAN FRANCISCO AND LOS ANGELES RECEIVE SUBSTANTIAL APPROPRIATIONS FROM CALIFORNIA LEGISLATURE**

**A New State University Medical School in Los Angeles.**—Medical Education in California will have reason to record, A. D. 1946,—for in this current year, a new medical school has been created, as one of the departments of the University of California. The new institution will be located in Los Angeles,—perhaps as a professional school allied to the "University of California at Los Angeles." In CALIFORNIA AND WESTERN MEDICINE for February, the proposed school received comment on page 66.

Governor Earl Warren signed on Wednesday, February 20, the initial appropriation bill for \$7,500,000, enacted by the California Legislature.

Physicians throughout California welcome this new and much needed medical institution, and good wishes are voiced for a long and prosperous career. Congratulations are also extended to the group of medical and other citizens who carried on the campaign of education to show the need of an additional medical school in California, and to Governor Earl Warren for his generous support of the plan.

\* \* \*

**University of California Medical School in San Francisco.**—Old Toland College of San Francisco (1862-1906), absorbed by University of California in 1906, and since that time of increasing growth and influence, operating in buildings on the former Affiliated Colleges site, now known as San Francisco Medical Center, also receives a substantial addition to its capital funds. The Legislature approved Assemblyman Gardiner Johnson's bill for a \$4,000,000 appropriation, and on Wednesday, March 6, 1946, Governor Earl Warren signed the Act and made the money available. (For plan of buildings, see page 142.)

In addition, from former war-year sessions of the Legislature will come about \$2,000,000 that was earmarked for additional construction and facilities at the Medical Center; and designed to meet needs in the Medical Library and Departments of Dentistry and Pharmacy, and School of Nursing. (See in this issue, on page 141.)

For these appropriations to further develop the facilities and opportunities for service at the University of California Medical School in San Francisco, appreciation is likewise expressed by the medical profession.

**V.A.-C.P.S.: PLAN WILL BE IN ACTIVE OPERATION IN MARCH**

**Regional Offices Will Permit Early Operation of the V.A.-C.P.S. Plan.**—In the February issue of the OFFICIAL JOURNAL, the opening editorial referred to the important contract entered into between Federal Veterans' Administration and California Physicians' Service.

In the current issue, appears the fee schedule mutually accepted. (See page 144.)

Members should scan this schedule to convince themselves the fees that will be received for professional services to be rendered to soldiers and sailors of all recent wars (Spanish-American, World War I and World War II)—to whom all of us are under massive obligation—are equitable; and with certainty of payment, all that could, in fairness, be asked from the Government.

It is possible that California may shortly have within its borders as residents, as many as 2,000,000 veterans. This is a large segment of California's population, and a governmental plan that permits maintenance of private practice and individual physician-patient relationship for so many citizens, plus affiliations with their families and friends, is something, in troublous times such as the present, that is worthy of gratulation to all concerned.

The V.A. officers are establishing two regional bureaus in California, one for the northern and the other for the southern section of the State. To permit prompt checking and to expedite giving of professional services to eligible veterans by C.P.S. members, a V.A. physician with his own clerical aides has already been assigned to each of the C.P.S. offices in San Francisco and Los Angeles.

*Pharmaceutical Profession Studying Medical Service Plans*

The American Pharmaceutical Association and the National Association of Retail Druggists have appointed a Joint Committee to study various plans proposed to provide medical care in which either the insurance principle is applied, or in which state funds or federal funds are made available.

The purpose of this study is to determine the extent to which pharmacists and pharmaceutical associations may participate in working out these plans or suggesting modifications or substitutes for them.

The Committee has no preconceived ideas as to the recommendations which it wishes to make to the pharmacists of the Nation on this subject. It wishes to make a factual study of available plans and procedures and report the facts as they are found to the two national organizations as a basis for possible action.

*Antonij Van Leeuwenhoek (1632-1723).*—While Leeuwenhoek was not a physician and had no formal scientific training, he was a very great microscopist and contributed many "firsts" to the progress of medicine. Among them are his accurate representation of bacteria, spermatozoa, red blood cells, parasitic and entozoic protozoa; and a complete demonstration of the capillary connection between arteries and veins, providing the final link in the chain of Harvey's discovery of the circulation of the blood. His microscopes, which he made himself, had a maximum magnification of 160 diameters.—Warner's *Calendar of Medical History*.

EDITORIAL COMMENT<sup>†</sup>

## DIETARY CONTROL OF RENAL HYPERTENSION

In 1944 Grollman<sup>1</sup> of the Department of Experimental Medicine, Dallas, Texas, suggested a simplified method for the production of chronic renal hypertension in the mouse, rat, rabbit and dog. The method consisted essentially in passing a loop of cotton thread or tape over the two poles and body of the kidney and tightening the ligature sufficiently to deform normal kidney shape. He found that about 20 per cent of the rats and rabbits develop a moderate degree of hypertension following such compression of a single kidney. About 70 per cent develop pronounced hypertension following bilateral renal compression.

In a typical experiment on dogs, the blood pressure rose from a normal of about 12 mm. Hg. to 150 mm. Hg. during the first two months after unilateral renal compression. The second kidney was then compressed, following which the pressure rose to 200 mm. Hg. The maximum was reached by the end of one year. The pressure remained at this high level for the next 8 months during which the animal was under observation. In rats a chronic hypertension of about 170 mm. Hg. was regularly produced by similar bilateral compression.

The ease and regularity with which hypertension can be produced in rats led Grollman<sup>2</sup> to select these animals for a study of the possible therapeutic effects of various types of diet. In a typical experiment pulverized Rockland Farm rat ration was dialyzed for 4 to 5 days, till all chlorides had been removed. The dried dialyzed diet was then enriched with synthetic vitamins (thiamin, riboflavin, hexabione, calcium pantothenate and niacin), cod-liver oil, and Osborne-Mendel salt mixture from which all sodium salts had been excluded. Twelve hypertensive rats, whose average blood pressure was 17 mm. Hg. were changed from the routine laboratory diet to this dialyzed food. Within 6 days their average blood pressure had fallen to 125 mm. Hg., at which low level it remained till the end of the experiment (18 days). On returning these rats to the routine stock diet, the hypertensive state was restored quantitatively within 6 days. Similar lowering of the hypertensive state was noted in rats placed on a diet composed entirely of ground peanuts, soy beans, rice and potatoes.

In attempts to determine the essential factor in this therapeutic effect it was found that the anti-hypertensive properties of the dialyzed diets could be completely destroyed by the addition of 1 per cent NaCl, while its anti-hypertensive titer was

not reduced by the addition of 1 per cent KCl. From this and other data it seemed probable that radical sodium restriction is the essential factor in overcoming renal hypertension in rats.

In order to determine whether or not the marked reduction in blood pressure induced by radical sodium restriction for long periods of time is deleterious to previously hypertensive animals, 62 hypertensive rats were divided into 2 equal groups, matched as to their blood pressure. One group received the regular stock diet. The other group was given the dialyzed low sodium diet. By the end of 100 days, but 8 (or 25 per cent) of the regularly fed rats had survived. The concurrent survival rate in the low-sodium group was twice as great, i.e., 15 rats (or 50 per cent). The low-sodium, anti-hypertensive diet is thus apparently beneficial insofar as duration of life is concerned.

The mechanism of the anti-hypertensive effects of sodium restriction has not yet been determined. It is known that there is a "dry edema" or accumulation of salt and water in the tissues of hypertensive patients. Grollman postulates that when subjected to a drastic sodium restriction the hypertensive rats rid themselves of this plethora of salt and water in the fixed tissues, with a secondary reduction in blood pressure. This and other suggested possibilities are now under investigation.

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## TELEKINETIC ANTIBODY REACTION

A revolutionary new theory of antigen-antibody reaction is suggested by Rothén<sup>1</sup> of the Rockefeller Institute as a result of his studies of the physio-chemical properties of multimolecular antigenic films.

About ten years ago Langmuir<sup>2</sup> and associates developed a method of transferring materials spread as a monomolecular film on a bath surface to highly polished stainless steel slides. The transferred material was held in place by a thin layer ("reference film") of barium stearate, uranyl acetate or other adhesive material. Thus transferred the mono-film may be subjected to chemical reactions and the resulting changes in its thickness measured by optical methods.

Chambers<sup>3</sup> and his associates of the University of Pennsylvania, adapted the Langmuir technique to the preparation of monomolecular and multimolecular films of bacterial antigens. They exposed these immobilized or fixed antigenic films to specific immune serum. After thoroughly washing the exposed slides with saline solution and distilled water, the increased film thickness resulting from union with homologous antibodies was

<sup>†</sup> This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

measured by refraction methods. Control tests were made with normal serum and with heterologous antiseraums.

Adopting the Chambers technique Rothen and Landsteiner<sup>4</sup> of the Rockefeller Institute found that a monomolecular layer of bovine albumen 6 to 8 Å thick, would attract and hold firmly a sufficient amount of antibovine antibody to increase the thickness of the film by about 40 Å. Heterologous antibodies gave no appreciable increase. This means that a single layer of bovine albumen would attract and firmly hold about 10 superimposed layers of specific antibody. In this latest work Rothen<sup>1</sup> tested multimolecular films. He found that if the number of bovine albumen layers was increased to 2, the thickness of the adherent antibody film was increased to about 60 Å. With 4 bovine antigenic layers the increase was to 104 Å, and with 8 layers to 149 Å. Control tests with heterologous (anti-egg-albumen) antibody gave negligible increases.

These data show that the effective range of specific attraction between antigen and antibody is "in the order of hundreds of Å." Rothen found that this telekinetic attraction is effective through a thin biological membrane. He tested membranes consisting of 6 to 10 superimposed layers of egg albumin. Through this egg albumin screen the antigen would attract and firmly hold as much as 86 Å of homologous specific antibody.

Rothen offers no theory to explain this presumptive telekinesis. He believes, however, that it is of "major importance from the standpoint of biology, [since] the reaction offers a very interesting example of the physical forces involved between large molecules." If so, the implied specific electrodynamic attraction sphere surrounding each protein molecule would have numerous basic applications in physiological and biochemical research. It might render many of the conventional theories of immunity of little more than historic interest and would have numerous other clinical applications. These and other suggested possibilities are now under investigation.

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*Casimir-Joseph Davaine (1812-1882).*—"I congratulate myself to have so often been the follower of your scientific researches"—wrote Pasteur to the man who, with Rayer, was the first to see the bacillus of anthrax. This French pathologist, parasitologist, and experimenter, was an initiator in every sense of the word. His treatise on animal parasites of man and domestic animals was an important one, as were those on infective diseases and septicemia.—Warner's *Calendar of Medical History*.

#### American Medical Association Plans a National Sickness Insurance Program

Organized medicine, through the Board of Trustees of the American Medical Association, on February 16, announced preliminary plans for the development of a nationwide system of voluntary sickness insurance protection, to be operated on a non-profit basis by local medical groups.

Details of the program, including costs, benefits and standards, now are being worked out by a newly formed subsidiary federation, known as Associated Medical Care Plans, Inc. Details should be ready for early release to the public.

While premium charges will vary in different parts of the country, the average cost to any individual policy holder will be "considerably less" than the \$144 annual payroll deduction suggested under President Truman's compulsory health insurance program.

In setting up standards of acceptance for voluntary prepayment medical and hospital care plans now in operation, the trustees and the A.M.A. Council on Medical Care, have decreed all such plans must meet the following requirements before they may display the Association's seal of approval.

(1) Have the approval of the State or county medical society in the area in which they operate.

(2) The medical profession in the area must assume responsibility for the medical services included in the benefits.

(3) Provide free choice of a qualified doctor of medicine, and maintain the personal, confidential relationship between patient and physician.

(4) Be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

Benefits under any of the plans, it was stated, may be in terms of either cash indemnity or in units of medical service. A house call would count for so many units and a visit to the physician's office would count for a varying number of service points.

The subsidiary medical plans care group, which is engaged in coördinating the various prepayment programs now in operation, also will seek to establish a reciprocal relation among all plans to permit subscribers to transfer their membership from one state to another. A central clearing house is to be located at A.M.A. headquarters in Chicago.

#### Seven Times As Many People Now Own Life Insurance As In 1900

Year	Number of Policyholders	Average Amount Owned Per Policyholder
1900	10,000,000	\$860
1918	31,000,000	\$960
After World War I		
1945	71,000,000	\$2,175
After World War II		

Despite the fact that seven times as many people own life insurance now as in 1900, there are fewer full-time ordinary life insurance agents in the business. The number of full-time agents decreased 31 per cent since the start of World War II. In the past year new full-time ordinary life agents entering the business were 55 per cent fewer than in 1940, according to the annual census of life insurance agents, just released by the Life Insurance Agency Management Association of Hartford. Ordinary companies showed a 40 per cent increase in sales of new insurance during the six-year period in spite of the decrease in agents.

# ORIGINAL ARTICLES

## Scientific and General

### CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH: ITS ADMINISTRATIVE ORGANIZATION\*

WILTON L. HALVERSON, M. D.  
*San Francisco*

THE California State Department of Public Health, which is the second oldest in the nation, was established on April 15, 1870, only 20 years after the formation of the State government.

The first State Board of Health consisted of seven physicians appointed by the Governor and was primarily an advisory and informational body with exceedingly limited powers. In 1905 the Legislature expanded these powers to provide for bureau organization. From time to time additional bureaus and divisions were established under the supervision of the board.

The State Board of Health now consists of eight members: seven physicians, including the director of the department, and one dentist. Members are appointed by the Governor for four-year terms, so staggered that there are always some experienced members to give continuity to policy. The board functions as a policy-making, regulatory, judicial, and licensing body.

The State Director of Public Health is the executive officer of the board and the administrative head of the department. It is his duty to administer the laws and regulations of the board pertaining to public health, to observe sanitary and public health conditions throughout the State, and to take all necessary precautions to protect the State in its sanitary and public health relations with other states and countries.

The legal duties of the Department of Public Health include: Examination into the causes of communicable disease in man and domestic animals; investigation of the sources of morbidity and mortality and the effects of localities, employments, conditions and circumstances on the public health; licensing of hospitals coming under the Hospital Act of 1945; detection and prevention of adulteration of food and drugs; examination for and the prevention of pollution of sources of public water and ice supplies; and preparation and distribution at cost of anti-toxins, vaccine, and other approved biologic products for the control or prevention of communicable disease. The department may advise all local health authorities, and when in its judgment the public health is menaced, it shall control and regulate their action.

The State department has as one of its principal functions the encouragement and stimulation of local health departments capable of meeting the public health needs of the areas which they serve. Direct public health service to the people of California is given mainly by local public health departments, the State department giving only such direct service as cannot be provided locally. The chief way in which the department works toward the accomplishment of adequate local health departments is through providing the following services:

1. Leadership in assisting communities to recognize their public health needs;
2. Financial aid in the establishment and strengthening of local health services, including the provision of staff and other resources;

3. Provision of educational opportunities for staffs of local health departments;

4. Establishment of standards of service and personnel; and

5. Coördination of the total public health program within the State and of local, State, and Federal programs.

In January, 1945, the administrative structure of the Department was reorganized by the Director with the approval of the Governor. The activities of the Department are now conducted by five Divisions with supervision over fourteen Bureaus.

#### DIVISION OF ADMINISTRATION

The Division of Administration includes three bureaus: Business Management, Records and Statistics, and Health Education.

The Bureau of Business Management is responsible for fiscal and personnel control, accounting, and office management.

The Bureau of Records and Statistics is now responsible for registration and analysis of births, deaths, and marriages. It is planned that the bureau will be responsible for the recording and analysis not only of vital statistics but also of morbidity and service records.

The Bureau of Health Education conducts a Statewide program of education of the public on health problems and fosters local community organization for the solution of public health problems through education. Working with the State Department of Education and local health and school departments, it also seeks to improve the quality of school health services and instruction.

#### DIVISION OF PREVENTIVE MEDICAL SERVICE

The Division of Preventive Medical Service includes six bureaus.

The Bureau of Maternal and Child Health conducts activities for the improvement of the health of mothers and children, such as conferences and clinics in areas where such services are not supplied locally; enforces board regulations pertaining to institutions receiving maternity cases; conducts the State program for the aid of crippled children; administers the emergency maternal and infant care program which provides medical and hospital care for the wives and infants of servicemen; and registers school audiometrists.

The Bureau of Tuberculosis coördinates the Statewide program for the prevention and treatment of tuberculosis. Its chief services are the establishment and maintenance of high standards in sanatoria throughout the State, the administration of the State subsidy law, the conduct of x-ray surveys, and the development of effective case finding services.

The Bureau of Venereal Diseases administers the venereal disease control program which includes considerable Federal and State financial assistance to local health departments conducting venereal disease case-finding programs and free public clinics and laboratories. It administers the laws requiring premarital and prenatal examinations for syphilis.

California law requires the reporting of 52 different communicable diseases to the local health officer who in turn must report all such cases to the State Department of Public Health. The Bureau of Acute Communicable Diseases records the number of cases of each reportable disease, the total number of deaths caused by the disease, the age and racial distribution, the localities in which the disease occurred, and other information of this kind. From these records, trends of diseases are determined which are useful to the State and local authorities in planning their programs for the improvement of the pub-

\* An official statement appearing in "California's Health," official bulletin of the California State Department of Public Health.

lic health and to control or prevent epidemics. Through immediate knowledge of an outbreak of a disease, the bureau is enabled to take action to prevent spread, and, in some cases, to remove the cause.

The Bureau of Public Health Nursing is responsible for the development and maintenance of high standards in public health nursing throughout the State. To accomplish this objective, the bureau assists local health departments and other agencies to obtain qualified public health nurses; offers advisory service to public health nurses and local health agencies; and maintains an educational program open to all public health nurses in the State.

The Bureau of Adult Health is responsible for programs for the protection of the health of industrial workers from both occupational and general health hazards. It assists local health departments to develop their programs and services in industrial health and provides direct services (medical, engineering, and nursing consultations and studies) to individual industries. The bureau maintains a laboratory for the analysis of samples of materials used in industrial processes which may be hazardous to health.

#### DIVISION OF ENVIRONMENTAL SANITATION

The Division of Environmental Sanitation includes two bureaus, the Bureau of Sanitary Engineering and the Bureau of Food and Drugs.

Community water supply and sewage disposal in California are regulated through permits issued by the State Department of Public Health. In each case, action is based on investigations and reports made by the Bureau of Sanitary Engineering.

In order to reduce to a minimum the danger of water and insect-borne disease, the bureau maintains supervision of water supplies; sewage disposal systems; industrial waste disposal; beach, stream, and watershed pollution; mosquito control; and the handling of shell-fish. The work, which is primarily investigative, advisory, and promotional, is conducted through and with local health, water, and sewer departments. The bureau assists local authorities to safeguard the general sanitation of communities in emergency situations such as serious floods, earthquakes, fires, or other catastrophes.

A Section on Sanitary Inspections makes surveys of sanitary conditions, particularly related to the disposal of garbage and of sewage in areas where there are no community sewage disposal systems. This section conducts surveys throughout the State to ascertain the presence of disease in rodents, particularly plague, and assists local health officers in preventing the spread of rabies.

The Bureau of Food and Drugs is charged under California law with the responsibility for the detection and prevention of adulteration and mislabeling of foods and drugs produced within the State. The bureau cooperates with the Federal Food and Drug Administration in the control of products which cross State lines. Within the bureau is the section of Cannery Inspection which administers and enforces California laws governing the canning and packing of meat and nonacid fruit and vegetable products.

#### DIVISION OF LABORATORIES

The Division of Laboratories engages in six principal activities: diagnostic procedures involving bacteriologic and serologic examinations related to the control of communicable diseases; manufacture and distribution of biologic products and of one per cent silver nitrate outfit; analysis of food and drugs, required primarily for the enforcement of the laws relating to the purity of such products; analysis of water and sewage, for the pur-

pose of insuring the safety of water supplies; and enforcement of laws that require licensing of manufacturers and distributors of biologic products, that regulate clinical and public health laboratories, and that require the licensing of laboratory technicians.

The Virus Laboratory examines specimens for the diagnosis of virus diseases such as encephalitis and, through a grant from the Rockefeller Foundation, conducts extensive research to determine the cause, epidemiology, and methods of controlling influenza.

Other research in the cause and control of communicable diseases and in methods of improving public health laboratory procedures is also conducted.

#### DIVISION OF LOCAL HEALTH SERVICE

The Division of Local Health Service promotes the establishment and development of full-time local health departments staffed with qualified public health personnel and conducting programs meeting the recommended standards of public health practice. The relationship of the division to local health departments and officials is advisory, except insofar as the bureau administers State and Federal funds made available to local health departments. By utilizing the professional personnel from the other divisions of the department, the Division of Local Health Service serves to coordinate the varied programs of the department.

(Note.—Articles relating to the history of the California State Department of Public Health have appeared in the following issues of CALIFORNIA AND WESTERN MEDICINE: Editorial "A National Department of Public Health," February, 1937, page 74; "Historical Notes on Public Health in California," article by Guy P. Jones, Sacramento, October, 1937, page 250; Article, "The Platform of the American Medical Association," December, 1939, page 394; Editorial "Federal Department of Health Officially Proposed by Thomas M. Logan, M.D., of California in 1871," January, 1940, page 2; "National Department of Health Proposed in 1871: By Thomas M. Logan, M.D., of California," article by Walter M. Dickie, M.D., San Francisco, January, 1940, page 6; "Benjamin Franklin Keene, Founder of the California Medical Association," an article by Louise F. Hays, Atlanta, Georgia, May, 1942, page 27; Editorial "Thomas M. Logan, M.D., Co-Founder of California Medical Association; His Efforts in 1872 to have United States Establish a National Department of Health, With Its Chief in the President's Cabinet," July, 1945, page 2; "Thomas M. Logan, M.D., Organizer of California State Board of Health and a Co-Founder of the California Medical Association," article by Guy P. Jones, San Francisco, July, 1945, page 6; "Early Public Health in California," an article by Guy P. Jones, San Francisco, December, 1945, page 275.†)

*Jan Swammerdam (1637-1680).*—The outstanding work of Swammerdam is contained in his history of insects published in 1669. By his studies he confirmed the theory of Harvey that there is no self-generation of small insects. Swammerdam was an expert in microscopic dissection, and is given recognition for being the first to see and describe the red blood corpuscles. Most of his life was devoted to intensive efforts in minute anatomy and embryology.—Warner's *Calendar of Medical History*.

† Addresses of Department of Public Health of the State of California follow:  
San Francisco—668 Phelan Building, 760 Market Street, San Francisco 2; Underhill 8700.  
Sacramento—631 J Street.  
Los Angeles—State Office Building, 217 West First Street; Madison 1281.  
Director, Wilton L. Halverson, 668 Phelan Building, 760 Market Street, San Francisco 2.

## TYPHOID FEVER OUTBREAK TRACED TO CREAM FILLED PASTRIES\*

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**A**N outbreak of phage type E typhoid fever occurred during June and July, 1945, in southern Alameda County, California, involving twenty-one primary cases. The source of the infection was traced to cream filled pastries prepared and consumed at a local restaurant. An employee of the restaurant, a pastry cook, was identified as the carrier responsible for the outbreak. An interval of fifty-one days elapsed between the onset of the first case and the date when typhoid fever was first definitely diagnosed. Investigations were carried on jointly by the State Department of Public Health and the Alameda County Health Department.

### HISTORY OF OUTBREAK

On July 25, the Bureau of Acute Communicable Diseases, State Department of Public Health, was notified by the Division of Laboratories that *Eberthella typhi* had been recovered from feces and/or blood of two persons residing in southern Alameda County. In the preliminary investigation of these cases, it was discovered that both had attended an anniversary dinner of the Pleasanton and Livermore societies, Chapters of the Native Daughters of the Golden West, held at a popular restaurant near Niles, Alameda County, on the night of June 28.

Further questioning disclosed the interesting information that of the thirty-four persons attending the dinner, nearly one-half had subsequently become ill. This fact was well known to many of the women attending the celebration, several of whom had already decided that the June 28 dinner was responsible for their common, undiagnosed malady. A number of the ill persons were receiving medical care at this time, but the correct clinical diagnosis had not yet been made.

With the etiological diagnosis definitely established in two individuals, other members of the group were visited and all persons with a history of recent, unexplained illness were required to submit specimens of feces and blood for laboratory examination. *Bacillus typhosus*, phage type E, was recovered from the feces or blood of fifteen of the thirty-four ladies who had attended the dinner. In this group of fifteen clinically ill persons there was one death with typhoid fever as the assigned primary cause.

The dates of onset were between July 3 and July 17. The prominent symptoms were fever, headache, abdominal pain, muscular aching, and diarrhea. The Widal test was usually positive and in three cases the organism was recovered by blood culture.

One secondary case has been reported. A four-year-old grandchild of one of the fifteen Native Daughter patients became ill following a visit to the home of her infected grandmother. The phage type of the recovered organism was type E.

### EPIDEMIOLOGIC HISTORIES

Epidemiologic histories taken from all ill persons immediately confirmed the suspicion that the source of the

infection was closely related to the June 28 anniversary celebration at the Niles restaurant. There was no other common association of the infected persons during the probable incubation period. Since it could reasonably be assumed that the gastrointestinal tract was the portal of entry of the organism, any substance ingested by the ill persons during the evening was suspect. Foodstuffs were, of course, a likely offender.

It was determined that no food or drink was consumed either before or after the dinner by any ill person which could have been accessible to other infected individuals. It seemed possible to conclude that the infection was acquired during the time the group assembled at the restaurant.

The menu consisted of soup, mixed green salad, fried chicken, potatoes, commercially canned string beans, coffee, rolls (no butter), fruit cobbler, ice cream, banana cream pie, and cake. Only three foodstuffs were uniformly eaten by all of the fifteen cases: chicken, potatoes, and banana cream pie. One of the three could be expected to be the vehicle. Fried chicken and potatoes could be ruled out presumptively because of the type of food, mode of preparation, and lack of opportunity for multiplication of the organisms.

Banana cream pie remained to be considered. Cream pastries are historical offenders, offering good cultural media, often in combination with ideal conditions for incubation and multiplication of organisms. It seemed probable that the vehicle responsible for transmitting the infecting dose of *E. typhi* was the banana cream pie.

When it became apparent that the infection was acquired at the restaurant, all food handling personnel were required to submit specimens of feces, urine, and blood for examination. The history of each was also obtained. Phage type E typhoid bacilli were recovered from the feces of two employees: a waitress, J. L., and the pastry cook, E. G.

### REPORT OF CASES

**CASE 1.**—J. L., who was employed as a part-time waitress, had the habit of sampling what she served, especially pie and cake. Her onset with phage type E typhoid fever was on July 3. She continued to work as a waitress until July 15, when a 104 degree fever forced her to bed. No history of a previous enteric illness could be obtained.

**CARRIER 1.**—When questioned, E. G., the pastry cook, was not ill. He readily admitted hospitalization for a febrile illness diagnosed by a physician as typhoid fever, in Des Moines, Iowa, in 1921. After a satisfactory clinical recovery and on the advice of his physician, he did not return to his regular occupation as a baker until one year later. Upon his return to work, he continued his occupation as a baker in Des Moines, Iowa; Kansas City, Missouri, and finally California. During his eight years of California residence, he was employed as a baker and pastry cook at prominent hotels in San Francisco, Berkeley, Sacramento, Richmond, Del Monte, and Palm Springs. In this period, many Californians consumed his specialties. His estimate: one million customers in eight years.

On February 26, 1945, E. G. accepted the position of pastry cook at the Niles restaurant. He rapidly built a reputation for his pastry specialties which extended into several surrounding counties.

### COMMENT

Pies were one of E. G.'s specialties. One San Francisco patron had enjoyed them on twenty-six consecutive Sundays. On June 28, E. G. prepared ten to twelve banana cream pies according to his standard formula. Pie dough was prepared by hand and shell-baked until brown. The filling consisted of a standard commercially packaged vanilla cream pudding powder, plus eggs, which were added to a quantity of milk and heated in a double boiler for ten minutes. The filling was then placed in a large pan to cool.

\* From the office of the Bureau of Acute Communicable Diseases of the California State Department of Public Health, San Francisco, and the office of the Health Officer of Alameda County, Oakland, California.

Submitted for publication, December 15, 1945.

Bananas were peeled and sliced by hand into each pie shell. The cream filling, now nearly cool, was added, and the pies were then allowed to stand for an hour at room temperature for further cooling. Final touches consisted of applying meringue frosting (pre-cooled egg whites beaten stiff) and browning the pies in a 450 degree oven for five minutes. On June 28, the pies were finished between 1:00 and 1:30 p.m. and placed in a storage case (temperature 82 to 84 degrees) until serving time at about 6:00 p.m.

Pies were often cut by E. G. himself. This operation consisted of dipping the cutting knife in a can of hot water between each slicing maneuver to aid in cutting the meringue smoothly. Any frosting which clung to the knife was removed by pulling the blade between thumb and forefinger.

In our discussion with E. G., it was learned that of the ten or twelve banana cream pies prepared on June 28, only an estimated seven were served to the Native Daughters. The remainder were presumably eaten by the restaurant's regular clientele. This required an answer to the question which immediately posed itself: who had consumed the remaining pies which had been prepared at the same time, using common ingredients and identical technique? Other cases of typhoid fever outside the Native Daughters group would logically be expected to occur. None had been reported.

The management was unable to supply the names of persons who might have dined at the restaurant on June 28, with the exception of one small group, which was subsequently found to have escaped infection. During the examination of the restaurant's food handlers, it was deemed advisable to recommend temporary closure of the restaurant. This request was acceded to without delay. Health officers in surrounding counties were advised of the possibility of missed cases of typhoid fever occurring in their jurisdictions. Since no other way could be found to warn those who had eaten at the restaurant during the suspect period, a carefully prepared news release was given to newspapers of general circulation, advising immediate medical consultation in the event of unexplained, febrile illness.

#### OTHER CASES

Six additional primary cases of typhoid fever, phage type E, have subsequently been diagnosed (the last on September 2), all of whom admitted eating at the restaurant between May 20 and July 6.

(1) A. M. ate at the restaurant on May 20. Her onset with phage type E typhoid fever was June 4. (2) B. C. visited the restaurant on several occasions between June 26 and July 3, eating banana cream pie and cake; onset: July 15. (3) M. D. stopped in for a cream puff on June 29; onset: July 14. (4) L. B. recalled eating banana cream pie at a private celebration at the restaurant on June 29; his onset: July 11. (5) D. J. attended the restaurant with a party of eight on July 6. Two, including D. J., ate banana cream pie. D. J.'s companion had been vaccinated against typhoid fever in 1943. D. J. had not. His onset: July 13. (6) The infection in J. L., the waitress, has been discussed.

#### DISCUSSION

**Mode of infection.**—Epidemiologic investigation singled out the restaurant with certainty as the place of infection of the fifteen Native Daughters. Members were drawn from several communities and uniformly denied all other common association of the group during the preceding two months. Consideration was given to the possibility that the infecting dose of *E. typhi* might have been contained in some foodstuff brought to the restaurant by one of the group to augment the menu, such as butter. With

the exception of the birthday cake, none was discovered. The cake was easily eliminated since several of the infected Native Daughters and all of the cases outside of this group had not eaten it.

Each of the foodstuffs consumed at the dinner excepting the banana cream pie could be discounted as the possible source of infection, either because it had not been consumed uniformly by all ill persons or because it constituted an unlikely vehicle as to chance of contamination and suitability for multiplication of the organism (fried chicken, potatoes).

It seems probable that the filling of the banana cream pie and/or the bananas (during the slicing procedure) were contaminated by the fingers of E. G., the pastry cook. After the filling mixture was heated, it was partially cooled and turned several times by hand. Bananas were sliced, also by hand, into the pie shells. Filled pies stood at room temperature or slightly above for a period of five to six hours before serving. The five-minute browning of the frosting certainly did not produce lethal temperature for the rapidly multiplying organisms.

That the infecting food was heavily contaminated is attested to by the short incubation periods (three cases had onsets within five days, eleven cases within seven).

Initial investigations of the restaurant disclosed a single toilet for use of the kitchen personnel, located in the building's second story. Inadequate handwashing facilities were noted. Subsequent information disclosed that a second toilet was located in close proximity to the kitchen, containing no handwashing facilities of any nature. Information as to the existence of this toilet had been withheld.

Considering his occupation, why had not E. G. been responsible for other known outbreaks between 1921 and 1945? It is, of course, possible that he may have infected an occasional individual and yet escaped detection as a carrier. Our study bears out this possibility, since the twenty-one primary cases included in this investigation were apparently not all infected on the same date.

Contact with E. G. convinced us that he was a methodical and fastidious person. (Among other things, he kept a diary of all important events.) We were inclined to believe his statement that he was careful in his toilet habits and that the soiling of his fingers may have been a very unusual occurrence.

It is possible, though not yet proved, that he may be an intermittent shedder of *E. typhi*. No blood, stool, or urine examinations were made prior to July, 1945.

If it could be accepted that the soiling of his fingers with feces was a rare occurrence, that his handwashing technique was ordinarily adequate, and if it could be proved that he is an intermittent shedder of *E. typhi*, it would then seem that the chance, statistically, for the simultaneous occurrence of organisms in his stool, soiled fingers, unwashed fingers, and contact with a suitable cultural media might be sufficiently remote to explain what appears to be a remarkable run of good luck.

A second explanation for the apparent lack of previous outbreaks of typhoid fever attributable to E. G. should be mentioned. An undiagnosed illness in E. G., in February, 1945, could conceivably have been clinical typhoid fever, or, if an incidental illness, it may have activated a latent gall-bladder infection with resultant shedding of large numbers of organisms. Since acquired immunity of permanent duration usually follows recovery, an attempt was made to verify his original 1921 diagnosis. This was unsuccessful, since all records in the Des Moines, Iowa, institution where he was hospitalized were destroyed by flood, and we were unable to determine whether the clinical diagnosis of typhoid fever was verified by laboratory methods. *E. typhi* have regularly been recovered from E. G.'s stools on three occasions between

July 30 and October 1, which is of interest in determining his status as an intermittent shedder. Widal reactions have been positive in higher dilutions than would usually be expected in a carrier. This, however, may be explained on the basis of an anametic reaction.

*Index of suspicion.*—In the southern Alameda County outbreak, twenty-one reported cases of typhoid fever occurred with dates of onset between May 20 and July 17. Twenty-one cases had onsets between July 3 and July 17. Eighteen of this latter group lived within a radius of ten miles. The symptoms were only moderately severe in many patients, although of sufficient intensity to hospitalize ten persons. The dramatic decline of typhoid fever as a major cause of illness in the last fifty years has made the infection difficult to diagnose usually because it is not suspected.

*Phage typing of *Eberthella typhi*.*—Phage typing has received considerable discussion in recent literature.<sup>1,2</sup> Specific types A, C, E, F, J, L, and M of *E. typhi* are now recognized. Typing procedures were begun by the Division of Laboratories, State Department of Public Health, in July, 1943, and are now routine. Through June, 1945, six hundred and four blood, stool, and urine cultures, from three hundred and twenty-six individuals, positive for *E. typhi*, have been phage typed. Such a laboratory device lends itself admirably to the study of an outbreak of typhoid fever in the field, as was amply demonstrated in the 1944 epidemic (type C), in which the source of infection of eighty-four cases was traced to uncured cheese manufactured from raw milk. It was very helpful in studying the twenty-one cases discussed in this paper.

It is obvious that this procedure is of great assistance to anyone interested in studying the possible causal relationships between any two or more persons in whom *E. typhi* can be demonstrated.

#### FOOD HANDLERS' EXAMINATIONS

Following the typhoid fever outbreak discussed in this paper, the restaurant concerned has requested some type of routine examination of its foodhandling personnel. We believe that public health experience over the past fifty years has amply demonstrated that the usual type of infrequent medical and laboratory examination of food handlers will not prevent occurrences similar to the southern Alameda County outbreak. It is true that routine laboratory examinations of stool and urine will occasionally detect *E. typhi* in an apparently well person (food handler or otherwise), but the net effect of such a program when applied to food handlers is to give the public a false sense of security. Only a thorough history and physical examination, complete with appropriate laboratory tests repeated almost daily, could offer any reasonable guarantee against missing inapparent infections. Such a program is not feasible administratively, because of cost and lack of competent examining personnel.

The present trend in public health practice is to replace the unsatisfactory system of periodic medical and laboratory examination of food handlers with health department sponsored training courses in methods of modern restaurant sanitation. Such a course includes a discussion of habits of personal cleanliness.

#### CONCLUSIONS

1. Twenty-one cases of phage type E typhoid fever occurred in southern Alameda County, which were traced to contaminated cream-filled pastries. A carrier was identified.
2. The mode of infection is discussed.
3. Typhoid fever is no longer a common disease and

for this reason is occasionally misdiagnosed. It should be considered in any unexplained febrile illness.

4. Phage typing of *Eberthella typhi* is a valuable epidemiologic tool.

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576 Callan Avenue, San Leandro.

#### REFERENCES

1. James Craigie and Chun Hui Yen, *Can. J. Pub. Hlth.*, 29:448 and 29:484, 1938.
2. Alfred S. Lazarus, *Am. J. Pub. Hlth.*, 31:60, 1941.

## CORNEAL TRANSPLANTATION\*

#### REPORT OF CASE

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**I**NTRODUCTION.—Inasmuch as the literature on this subject has been reviewed exhaustively by Castroviejo in a recent paper, a further review in this discussion would be superfluous. The essence of this presentation will be found in the colored motion picture illustrations. This paper is a case report illustrated by a motion picture in color, concerning a patient with keratoconus in which corneal transplantation was done by the Castroviejo method.

#### REPORT OF CASE

Mrs. L. L., a 35-year-old white housewife, was first seen on February 3, 1944, with the complaint that for the previous two weeks she had been unable to see anything but light from either eye. She gave a history of having had conical cornea for many years. She had never been able to wear a contact lens in the left eye, but had worn one in the right eye with comfort. At the time this patient was first seen, her uncorrected vision was light perception in each eye. With a contact lens, she could read 20/70 in the right eye and 20/100 in the left. In the right eye there was a very large cone with many opacities in the posterior surface and the cornea was about one-third of the normal thickness. The left eye presented a similar picture except that the stroma over the cone was quite hazy and Descemet's membrane was bulging in the center where there was a staining area about two millimeters in diameter, characteristic of a vesicular keratitis.

Immediate treatment consisted in application of a pressure bandage and atropine. Seven days later, the cone was much flatter and the eye was much less irritated. The patient was very much discouraged and felt that life was not worth living under these conditions, inasmuch as she could hardly get around her own home and was unable to take care of her children.

She was advised to have a corneal transplantation. When suitable material could be obtained, a transplant was done by the Castroviejo technique; recovery was uneventful except that there was a small anterior synechiae in the lower outer corner of the transplant. This has caused no serious damage and no vessels grew into the transplant. During the first postoperative month, 400 R units of unfiltered x-ray were given. This transplant has remained quite clear to date. Two months after surgery, the vision in this eye was 20/30. With a small cylinder and a plus 3 sphere, the vision could be improved to 20/20.

The patient was so pleased with the result that she insisted upon having the other eye done. A corneal transplant, by the same technique, was done on November 9, 1944, and the pictures to be seen are those taken at that operation. One month after operation, the vision in this eye was 20/50 plus, uncorrected, and 20/30 corrected. No vessels have grown in, and the corneal transplant has remained quite clear.

#### INDICATIONS FOR CORNEAL TRANSPLANTATION

Determination of the indications for corneal transplantation in cases of conical cornea is important. These may be listed as follows:

1. When the tip of the cone begins to break down

\* Read before the Section on Eye, Ear, Nose and Throat, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

and a Descemetocle is formed, then corneal transplantation becomes mandatory.

2. When a patient is unable to wear a contact lens for a practical amount of time.

3. When the tip of the cone becomes so opaque that vision is not good even with a contact lens.

The advisability of doing transplantation in the presence of one good eye is always debatable. However, in threatened rupture this is mandatory.

#### OPERATIVE COMPLICATIONS

Complications may be divided conveniently into those occurring in the immediate postoperative period, and those occurring in the late postoperative period.

In the first instance, namely the complications occurring in the early postoperative period, that most to be feared is incarceration or prolapse of the iris. This particular complication is very prone to occur in those cases having transplantation for conical cornea, inasmuch as a very large section of the cornea is transplanted. The iris is in very close proximity to the wound and it is easily incarcerated. This complication is a difficult one to treat, inasmuch as manipulation during the immediate postoperative period nearly always leads to a cloudy segment. It is better perhaps to leave these alone unless there is a frank prolapse, and to make a secondary repair at a later date. It is to be noted that in cases in which incarceration occurs, it is doubly necessary to use x-ray following hospitalization in order to prevent vascularization of the transplant. Although in the past infection has been a complication to be feared, under modern conditions this is no longer so important.

In the late postoperative period the common complications are opacification of the transplant and vascularization. For the former there is little to be done, but in the latter x-ray is very helpful. It has been my custom to use approximately 400 R in divided doses of 50 R each. Doses can be given about five days apart. Consoling to the surgeon is the fact that if opacification of the transplant occurs, a retransplant can always be done. It is necessary, however, that the new transplant exceed the old one in size.

#### GENERAL POSTOPERATIVE COURSE

It has been my practice to leave sutures in for at least ten days. Some have argued that the sutures might damage the new corneal epithelium, but I have not found this complication in any of my cases.

As has been noted in the motion picture it has been your speaker's custom to place an air bubble in the anterior chamber at the time of operation. This indicates clearly whether the transplant fits properly and acts as a cushion for pressure changes, and this should help to avoid the complication of iris incarceration.

Your speaker generally sends his patients home in two weeks and they wear a pressure bandage for about a week longer; and are under atropinization for approximately a month.

#### COMMENT

It is necessary that the technique of corneal transplantation in cases with conical cornea be particularly scrupulous, inasmuch as the cornea is so thin. Such thinness adds very considerably to the difficulties of cutting the cornea accurately. When the marking knife is used the cornea has a tendency to buckle and when the scissors are used a clean cut is difficult to make. In the operation done for corneal leucoma in which the cornea is of normal or greater than normal thickness, the procedure is relatively easy. Furthermore, in the conical cornea cases a large transplant is necessary in order that

it may act as a support for the remaining portion of the cornea. The contrary is true in the corneal leucoma cases in which the cornea itself acts as a support for the transplant.

Following transplantation the question of the amount of astigmatism produced arises. In general, astigmatism is about of the same order as that found after cataract surgery, although in those cases that develop anterior synechiae the amount may be greater than normal, and at an odd axis.

It behooves ophthalmologists on the Pacific Coast to familiarize themselves with this type of procedure and to make use of it. There will probably be a great number of patients with corneal leucoma coming back from the armed services, who will require corneal transplantation. Too, there are those with conical cornea who have threatened rupture, or who are unable to wear contact lenses, who should be given the privilege of having this type of surgery.

#### SUMMARY

A colored motion picture was demonstrated to show the technique of corneal transplantation in keratoconus by the Castroviejo technique. A discussion of some of the complications was presented. Colleagues were urged to make the use of this type of surgery more widespread.

727 West Seventh Street.

### DEAFNESS—A MODERN APPROACH TO ITS TREATMENT

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IT might be said that in no other field of medicine more pessimism and "defeatism" is to be encountered than that which exists with regard to the treatment of deafness. The following pronouncements are examples of authentic statements by so-called authorities in the field of otology:

"Nothing can be done for deafness."

"The patient has nerve deafness, so there is no treatment."

"Your child is congenitally deafened and there is nothing that can be done. When he will be 5 or 6 years old, institutionalize him in a school for the deafened."

"We do not operate because of deafness."

"I can arrive at a diagnosis of deafness and tell whether my patients are improving without an audiogram."

#### ERRONEOUS STATEMENTS MAKE FOR PESSIMISTIC APPROACH

Fortunately, not one of these statements is true. But the disturbing fact remains that physicians in general and otologists in particular are so easily prepared to accept defeat in the treatment of deafness. Not even in the care and treatment of cancer patients has a comparable attitude of pessimism been allowed to become established almost without a challenge. But while cancer is notably a disease of old age, usually found in persons who have passed the prime of their active life, deafness is most harmful in childhood and youth. Moreover, the number of persons suffering from deafness is much larger than the number of cancer patients. It would, therefore, be no more than a socially and economically logical procedure to institute the most comprehensive research for the study and treatment of deafness. There is a great need for a few heavily endowed institutions with the sole purpose of furthering the research and advancing the clinical treatment of deafness. Such research centers would undoubtedly attract the keenest minds in

otology. It might even be possible to popularize the fight against deafness and to institute for this purpose another "March of Dimes."

#### REHABILITATION OF THE DEAFENED

The fact that deafness is not a deadly disease should be recognized as a good reason for the salvage and repair of persons with hearing defects. The deafened can find gainful employment more easily than the blind, but they fit themselves less smoothly into a normal social environment than those handicapped by other crippling diseases and infirmities. The rehabilitation of the deafened must be considered as a medical and social challenge of utmost importance; and only ignorance of the possibilities of social readjustment can lead to the misapprehension that institutions for the deaf are established for the purpose of ridding families of their handicapped and problematic members.

The observation has often been made that blind persons are, as a rule, of a happy and cheerful disposition. They frequently are vivacious and enthusiastic people of excellent social adjustment. Deafened persons, on the other hand, are not likely to present a similarly genial personality, unless they have received all possible medical treatment as well as guidance towards rehabilitation. Otherwise deafness will prove to be injurious and even ruinous to disposition and character, especially if the impairment begins in early life or develops to severe proportions. It takes a strong character indeed to overcome the trauma of deafness.

It has been the experience of the medical staff of the Armed Forces that the initial attitude of newly deafened patients is unfailingly negative. At first they will be downhearted and morose, profoundly hopeless, and completely uncooperative. In almost every case it proved difficult to overcome the emotional barrier; yet only in this manner was it possible to guide the disabled veteran towards renewed participation in a normal life.

If a deafened child is to grow into adulthood without developing a marked inferiority complex accompanied by compensatory and reactive mechanisms, great intelligence, patience and the willingness to undergo special education will also be required on the part of the parents.

#### INFANTS AND YOUNG CHILDREN PRESENT DIAGNOSTIC DIFFICULTIES

It is most difficult to arrive at a diagnosis of deafness in an infant, or in a child under 4 or 5 years of age. If the child is totally or severely deafened, the parents may note that it sleeps in spite of loud noises in its immediate vicinity, or that it fails to respond when spoken to. But generally deafness will be suspected only if the child does not learn to talk, or articulates with a pronounced speech defect. As it is unable to hear, it is equally incapable of reproducing sounds correctly. All too frequently such children are judged by lay people and even diagnosed by physicians as mentally defective. Institutions for the feeble-minded contain many children whose only defect is a hearing deficiency.

#### REPORT OF CASE

**CASE 1.**—When I began my first year of teaching in public schools, my fellow teachers made it a point to advise me not to waste my time trying to teach little Jerry anything. They were unanimous in their judgment that Jerry was mentally defective and that he should be seated at the back of the class, and kept out of the way. After a month of sincere efforts to teach Jerry, I finally agreed with my fellow teachers. For the rest of the year Jerry sat at the back of the room and was again ignored. Needless to say, this boy had already developed into a social misfit with a distorted personality. His knowledge was inferior to that of the other children. Even his family agreed that Jerry was "dumb" and suggested not to waste too much attention on him. But when two years

later routine hearing tests were given to the children of that school, poor Jerry was found to have struggled along under the handicap of a severe hearing deficiency. By that time, however, the feeling of inferiority had caused him to become a problem child.

#### COMMENT

Only a few weeks ago, a blind young lady of about 30 years of age came to my office for the treatment of a mild sinus infection. She was accompanied by her "seeing eye" dog. Everyone knows what an impressive sight such a pair make. Any blind person will attract attention and evoke pity and consideration. This young patient told me how valiantly her eye doctors had worked for months, trying to save her sight. Seven nationally and internationally famous eye specialists had been called into consultation on her case at the great eye clinic of the Presbyterian Medical Center in New York City. As an otologist it occurred to me that I have never witnessed an effort of comparable determination made in order to save a person's hearing.

Often it might almost seem as if the otologist would only begin to feel concerned about an ear disease, when the infection threatens to become fatal. In fact, a prominent otologist visiting Los Angeles a year or two ago made the remark which has already been quoted at the beginning of this article: "We do not operate because of deafness."

Any physician graduating from Medical School has but a limited understanding of the ear and the deafened patient. Unless he specializes in the field of otology, he is unlikely to learn much more on the subject; in fact, as time goes on he forgets part of his earlier knowledge. And even the otologist in his specialized training often learns little about deafness and the specific problems of the deafened as the emphasis placed upon the various problems is largely dependent on the interests of his teachers. Therefore, it is not surprising that, as a rule, otolaryngologists seem to find other branches of their specialty more interesting and otherwise attractive.

#### RECENT PREVENTIVE AND THERAPEUTIC MEASURES

Yet, in the last few years, an almost revolutionary change has taken place in the prevention and treatment of deafness. Dr. Julius Lempert has developed for the welfare of humanity one of the greatest, if not the greatest surgical interventions of the century giving the otosclerotic deafened improved hearing through the fenestration operation. But medical progress has also produced other methods designed to alleviate the sufferings of the deafened. It may, therefore, be useful to enumerate the various procedures which can find application in the treatment of deafness.

#### AN ENUMERATION OF POSSIBLE PROCEDURES

1. Nose drops—for the treatment of sinus infection, nasopharyngitis or inflammation and swelling of the eustachian tubes.
2. Sulfa drugs and penicillin (systemic)—for the systemic diseases which may cause deafness.
3. Tonsillectomy and adenoidectomy—especially adenoidectomy for the removal of adenoid tissue from the openings of the eustachian tubes.
4. Repeated adenoidectomy if indicated.
5. X-ray or radium treatment of the adenoid tissue blocking the entrance to the eustachian tubes.
6. External care for draining ears—dry wipes, swishes, aspirations and ear drops (sulfa drugs or penicillin).
7. Simple mastoidectomy.
8. Radical mastoidectomy.
9. Fenestration operation of Lempert, in case of otosclerosis.

10. Care and recommendations relative to general health—diet, environment, rest, etc.
11. Vitamins—especially vitamin B complex (but vitamins only if a vitamin deficiency exists. A well-balanced diet is preferable to synthetic vitamins).
12. Endocrine studies with special endocrine treatments if indicated.
13. Diagnosis of allergy and treatment if indicated.
14. Thorough checkup for foci of infection and their removal if found. In order of importance and frequency the foci of infection rank as follows: 1. Teeth; 2. Tonsils; 3. Sinus; 4. Miscellaneous (gall bladder, prostate).
15. Removal of noise trauma—noise whether high pitched, low pitched or mixed causes a high-toned, permanent nerve deafness.
16. Removal of any exogenous toxins, such as chemicals or other poisons at place of employment.
17. Removal of certain drugs that may cause deafness, such as quinine, salicylates.
18. Blood studies for syphilis, and treatment if indicated.
19. Diagnosis concerning intra-cranial tumors, and advice relative to surgery or treatment.
20. Establishment of possible malingering, and proper "treatment."
21. Determination of possible presence of hysteria, and proper "treatment."
22. Diagnosis of possible labyrinthitis (including Ménière's Syndrome) and treatment as indicated.
23. Explanation of handicaps of deafness to patient, parents, teachers and other associates, thus creating understanding, consideration and sympathy towards patient's possible abnormal reactions.
24. Discussion with patient, family and associates of abnormal social, psychologic and economic aspects of deafness.
25. Advice to deafened person to sit at the front of a school room or auditorium with the better ear towards the speaker.
26. Prescription of a hearing aid if necessary. The vacuum tube hearing aid is almost always preferable; bone conduction hearing aids should be prescribed only in rare instances.
27. Recommendation to study speech reading in a school for the deafened and to join a league for the hard-of-hearing.
28. Sustained and sympathetic interest in the patient's case, with due consideration of the psychological aspects of deafness and the depressing and introverting consequences of a hopelessly negative prognosis.
29. Advice and guidance of the patient relative to rehabilitation. Training schools are now being established, chiefly by the government for returning war veterans to teach them new and appropriate trades and skills.
30. Advice to the parents to beware of quacks.
31. Instruction to the patient and his relatives about the necessity of regular audiometric check-ups.
32. Routine audiometric hearing tests should be given each new patient seen by the otolaryngologist. Only in this way can early and obscure hearing losses be detected. No examination of the ear, nose and throat is thorough or complete without an audiogram.

#### IN CONCLUSION

The choice of treatments and procedures from which the patient is likely to derive the greatest benefit will depend upon the characteristic features of each individual case. But the fact that such a large selection of methods has been evolved should dispel any notion that nothing can be done for deafness.

65 North Madison Avenue.

#### CONGENITAL ATRESIA OF THE ESOPHAGUS WITH TRACHEO-ESOPHAGEAL FISTULA\*

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AND

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THE purpose of this communication is to review and further direct attention toward an anomaly of the gastro-intestinal tract, congenital atresia of the esophagus with tracheo-esophageal fistula. It is our wish to demonstrate the antemortem diagnostic roentgenographic findings and to show roentgenographically the pathologic anatomy as seen at necropsy.

Congenital atresia of the esophagus with tracheo-esophageal fistula is not a new entity, having been described in 1670, but it is an entity in which there has been a revived interest and a definite hope for cure with the advent of the present day scope of thoracic surgery and the newer chemotherapeutic methods. This malformation produces a syndrome which involves both the digestive and respiratory systems, and in which, without intervention, the outcome is death. In this presentation, therapeutic triumphs cannot be stressed.

#### CLINICAL MATERIAL

In twenty months with 3,630 unselected deliveries, we have had two cases in full term, apparently normal, healthy infants following a normal pregnancy and delivery at a U. S. Naval Hospital dependent service. Brenneman<sup>1</sup> states that in his experience it is the most frequent congenital anomaly of the gastro-intestinal tract with the possible exception of hyperplastic stenosis of the pylorus, and Vogt<sup>2</sup> estimates approximately two cases in eight hundred and fifty infant hospital admissions. The statistics as regards frequency of congenital atresia of the esophagus vary widely. The reported cases number about four hundred, but undoubtedly more occur than are recognized.

#### DEVELOPMENT

In the development of the esophagus, the lower portion forms from the pregastric segment of the foregut. A more cephalic portion of the foregut gives rise to the upper esophagus and the entire epithelial mold of the respiratory tract. The tracheo-bronchial rudiment cleaves from the upper esophagus by means of two longitudinal lateral infoldings. With the approximation of the infoldings, the respiratory tract is formed and continues to develop and branch at its free end. This separation occurs early and is present by the end of two lunar months. The diverse malformations of the esophagus actually have a wide range running from entire involvement of the passage to regional involvement, and from agenesis to doubling. With particular reference to congenital esophageal atresias, Vogt classified them into three main groups and subdivided the third group into three subgroups. Vogt's Type 1 is the very rare complete esophageal absence. Type 2 is where both the upper and lower esophageal segments end blindly, and Type 3 is where an esophageal communication, or fistula, with the respiratory tract exists. In Type 3a the upper esophageal segment communicates with the trachea or a bronchus.

\* This article has been released for publication by the Division of Publications of the Bureau of Medicine and Surgery of the U. S. Navy. The opinions and views set forth in this article are those of the writers and are not to be considered as reflecting the policies of the Navy Department, or the military service at large.

In Type 3b the lower esophageal segment communicates, and in Type 3c both esophageal segments have a communication with the tracheo-bronchial tree. Our cases were of the Type 3b, where the lower esophageal segment connects with the respiratory passages. This is the common type, and the one to be suspected until proven otherwise.

Why these esophageal malformations occur is a matter of conjecture. An incorrect cleavage of the longitudinal infoldings has been used frequently as a descriptive aid in understanding congenital esophageal atresia with or without fistula. This fits well with Vogt's classification. Various etiologic factors have been proposed such as intrauterine trauma, infection, extraneous pressures and others, which while applicable in one instance, fail when all possible lesions are considered, and so must be discarded. The proposal of a primary deficiency in the developmental capacities of the tissues concerned (Rosenthal,<sup>3</sup> Strong and Cummins<sup>4</sup>) is applicable and plausible. It is this theory with which we are in accord.

The clinical diagnosis of esophageal atresia with a tracheal fistula is rather stereotyped. There is a direct reflection of the anatomic problem involved with a dysfunction of the two systems, the respiratory and the digestive, being apparent. Soon after birth, attention is drawn to the respiratory system by the attacks of coughing, dyspnea, and cyanosis; then to the digestive tract when the infant fails to nurse normally, regurgitating his feedings, and drools and froths saliva persistently. Upon attempting to pass a soft rubber catheter an obstruction is met at about 12 cm. whereas the known distance to the stomach from the lips in an infant is approximately 17 cm. The course is, as stated, one of progressive dehydration, inanition, and bronchopneumonia which without operative intervention leads to death usually within a week. Our cases followed the usual course. Surgical intervention had been advised against because of the poor surgical risk of each infant at the time of consultation. The infants died on the fifth and fourth days.

#### ROENTGENOGRAMS

The typical antemortum roentgenograms are shown in Figures 1 and 2. Upon introducing a radio-opaque medium into the upper segment, the upper esophageal portion is outlined in atresia as a blind sac. Iodized oil is preferred to barium in this study to lessen the chance of a pneumonic process. Our first case is so shown in Figure 1. The presence of a tracheo-esophageal fistula is manifested by air within the stomach and the upper intestines. With a blind upper esophagus in a newborn, air could only be present here as the result of a communication by the lower esophageal segment with the respiratory passages. The clinical findings are those of a round, tympanitic, upper abdomen. The roentgenographic demonstration of air within the stomach and upper intestinal tract is shown in Figure 2. Figure 3 demonstrates the pathologic anatomy at necropsy as seen with the roentgenograms. Through the stomach into the esophageal phrenic ampulla, a tube was introduced, and a barium mixture injected. The barium outlined the lower esophageal segment, passed into the trachea through the fistula opening just above the carina, and then filled the tracheo-bronchial passages. It can be further noted that a small amount of barium entered the upper esophageal segment by spilling over at the epiglottis. The superior and inferior portions of the upper esophageal segment have been indicated on the roentgenogram in Figure 3, as the segment reproduced somewhat indistinctly, being overshadowed in the lateral view by the soft tissue density of the infant's arms.



Fig. 1. Case 1.—The blind upper esophageal segment is outlined as a blind sac by a radio-opaque medium.

#### TREATMENT

The confronting therapeutic problem is twofold. The infant must be given a means of taking food and liquid, also aspiration pneumonia must be prevented. However, before and if treatment is undertaken, an appraisal must be made, especially for other congenital anomalies, often of serious importance. In 72 cases of esophageal atresia with or without fistula at the Children's Hospital in Boston, Ladd<sup>5</sup> reports 23 infants without accompanying malformations while in other infants, there were 63 anomalies associated with atresia of the esophagus. These in themselves may require major surgical procedures or may even be incompatible with life. A necropsy was not performed on our first case, but no other anomaly was detected clinically. The second infant had a cord-like descending portion and inferior portion of the duodenum in addition to the esophageal lesion. Although this was not an entirely complete atresia as evidenced by air within the jejunum and ileum in a roentgenogram, the probable outcome, even had a successful esophageal repair been done, is obvious.

The method of therapeutic attack is surgical with a direct and an indirect approach. The direct attack is a single stage extra-pleural ligation of the tracheo-esophageal fistula and a primary anastomosis of the esophageal segments. With the indirect method, the fistula is tied off and a gastrostomy and an esophagostomy done; later a skin tube, or anterior esophagus, is constructed connecting the upper esophageal segment and

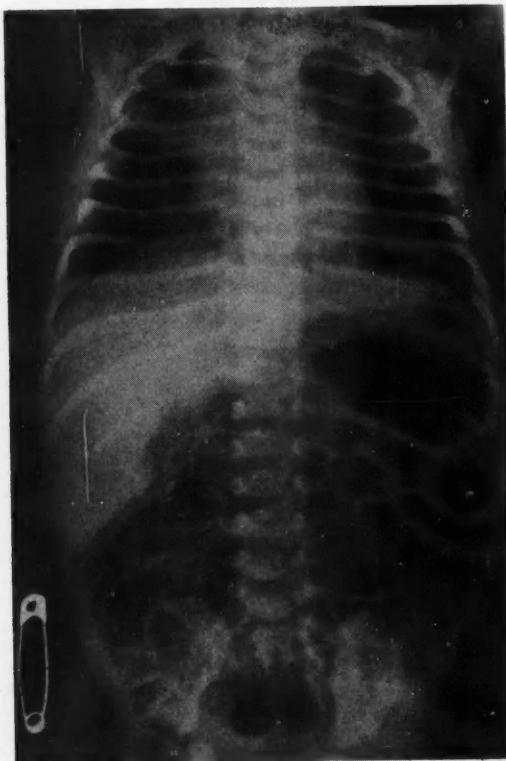


Fig. 2. Case 1.—Air within the upper intestinal tract is noted. In a newborn with a blind upper esophageal segment, air could be present thus only if an air passage communication existed. In Case 2 a similar roentgenogram was nearly identical.

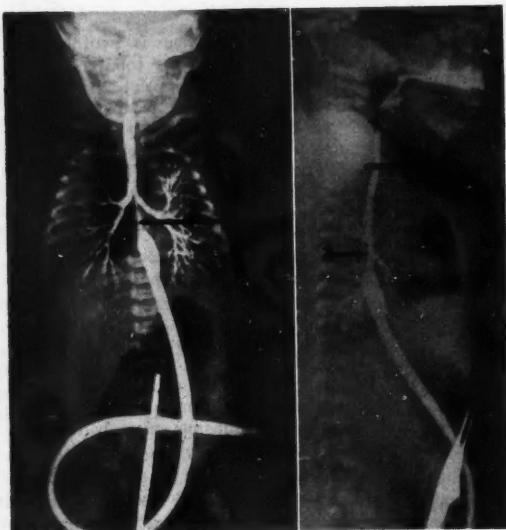


Fig. 3. Case 2.—The post-mortem roentgenographic findings are demonstrated. The upper (1) and lower (2) esophageal segments are indicated. See text. The soft tissue density of the arms partially obscures the upper segment in the lateral view.

the gastrostomy. Haight and Towsley<sup>6</sup> reported, in 1943, the first successful reconstruction by the direct method; the first child whose life was so salvaged was reported over three years old in 1944 (Haight<sup>7</sup>). Leven of St. Paul and Ladd of Boston each have a living patient about 18 months older in some stage of the indirect or multiple stage procedure.

#### COMMENT

Congenital atresia of the esophagus with tracheo-esophageal fistula is not a condition where striking, uniform, therapeutic successes are to be expected. The attending difficulties are multiple and great. However, Lam<sup>8</sup> reports from the literature, in 1945, 13 living of 36 patients operated upon by the direct method, and 15 living infants of 33 who are in some stage of the indirect method. Another writer, Vogt, in 1929, stated that if congenital esophageal atresia were as rare as it is fatal, we would be unable as yet to find the first recorded instance. The difference is momentous; in the span of a few years a new perspective has replaced that of a cold, hopeless outlook.

#### SUMMARY

A brief review to direct interest toward a not infrequent congenital anomaly has been presented. This is an anomaly in which there has been increasing interest and increased hope. Considerations as regards frequency, embryology, diagnosis, roentgen anatomy, and treatment have been discussed. Two cases from a U. S. Naval Hospital are included.

U. S. Naval Hospital.

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*Marcello Malpighi (1628-1694).*—To Marcello Malpighi goes the honor of having been among the first to apply the microscope to the study of animal and vegetable structure, and of being the founder of microscopic anatomy. He did extensive and valuable work on the anatomy of the silkworm and the morphology of plants. By his observations on the chick and its development he laid the foundation for the science of embryology. Though he described the red blood corpuscles in 1665, he was preceded in this by Swammerdam. He supplied a missing factor in Harvey's theory of the circulation of the blood from artery to vein.—Warner's *Calendar of Medical History*.

We owe gratitude to France, justice to England, good will to all, and subservience to none.

—Thomas Jefferson, *Writings*, Vol. ix, p. 420.

We must meet our duty and convince the world that we are just friends and brave enemies.

—Thomas Jefferson, *Writings*, Vol. xix, p. 156.

## CALCIFIED TRUE ANEURISM OF LEFT RENAL ARTERY\*

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AND

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WHEN Mathe reviewed the literature in 1932 he collected 55 cases of aneurism of the renal artery, the first reported in 1719, and added one case of his own. Since that time nine cases have been reported from abroad, and seven in the United States. We wish to add one more.

### REPORT OF CASE

C. B. L., age 52, whose only complaint was pain in the lumbar region, duration one month. It radiated anteriorly to the anterior superior spine, had not grown worse, was a severe ache in character, and had never been severe enough to necessitate narcotics. There were no urinary tract symptoms except nocturia one to two times, duration three months.

#### Past History:

Negative except for trauma in left lumbar region (kicked by a horse) 22 years before. At that time he had no hematuria, no symptoms except local soreness that did not prevent his doing his usual work.

#### Physical Examination:

White male 52 years of age, not acutely ill. Aside from being slightly undernourished, he appeared to be in good physical condition.

#### Pertinent Findings:

B. P. 160/100—peripheral arteries slightly palpable because of sclerosis.

#### Regional:

Neither kidney was palpable nor tender. No abdominal masses were found. External genitalia were normal. Rectal examination revealed a small normal prostate.

#### Results of Laboratory Studies:

1. E. K. G. Normal
2. R. B. C. 4,300,000. H. G. B. 90 per cent.
3. W. B. C. 8,300. Normal differential.
4. Kahn. Negative.
5. Urine. Specific gravity 1.015. Negative for sugar and albumin. Microscopic. 0 to 2 R. B. Cells. 4-6 W. B. Cells.
6. Sedimentation rate 30 mm. in one hour.
7. Blood sugar 89.2. Blood urea nitrogen 16.3 mgm.

#### Cystoscopy:

1. F. 24 B.B. cystoscope passed without difficulty. No residual urine.
2. No tumor, stone, nor ulceration seen.
3. Bladder capacity normal.
4. No trabeculation seen. No elevation of the bladder neck at 6 o'clock.
5. Prostatic urethra showed only slight congestion. No lateral lobe hypertrophy.
6. Right uretral orifice normal. Left uretral orifice showed slight edema without redness or ulceration.
7. F. 6 W.T. catheter passed without difficulty to each pelvis. No residual urine found. Specimens were negative except for a moderate number of W.B.C. from the left kidney.
8. Intravenous P.S.P. appeared within one and a half minutes.
9. Pyelograms were taken with  $\frac{1}{2}$  diluted neo-iopex.

#### Pyelograms:

Showed each kidney to be normal in size, shape, and position. No stones seen. Right was normal. Left revealed slight elongation and dilation of the upper calyx and an incomplete annular shadow situated near the hilus in the lower portion of the upper pole.

\* Read before the Section on Urology at the Seventy-second Annual Session of the California Medical Association, Los Angeles, May 2-3, 1943.

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The authors wish to express their appreciation to Cismondi, E. L., Pharmacist Mate Second Class, U. S. Navy, for his excellent photography.

#### Diagnosis:

Three diagnoses were considered in the order of their probability and immediate surgery was advised because of the second.

1. Calcified cyst.
2. Early new growth with calcified cyst.
3. Aneurism, renal artery.

#### Treatment:

Nephrectomy was done in the usual manner; the operative findings being:

1. Kidney grossly normal.
2. An aneurism of the posterior branch of the renal artery.
3. Renal artery (portion included in pedicle tie) was very sclerotic. There was considerable difficulty in making the tie as the artery was so friable it leaked at the point the clamp was applied, with moderate loss of blood from brisk hemorrhage. Postoperative course was normal. The patient was given one transfusion of 500 cc. citrated blood.

#### PATHOLOGICAL EXAMINATION

U. S. Naval Medical School, Washington, D. C., 11 December, 1940.

#### Gross Examination:

Specimen consists of left kidney, measuring 12 x 7 x 4.5 centimeters. The capsule is slightly adherent. The surface is smooth and deeply congested throughout. On section the cortex is rather thin and the markings are obscured by a yellowish-white cloudy appearance. The pyramids are congested. The pelvis shows increased fat. Pelvic mucosa and ureter are congested. The renal artery is cut three centimeters from its entrance into the kidney and divides into two branches one anterior and one posterior branch near its beginning has formed two sacculated aneurisms—the first is elongated and measures 2 x 1.5 x 1 centimeter, the second one is oval and measures 2.5 centimeters in diameter. The connection between the two sacs is 0.5 centimeter in length and 0.5 centimeter in diameter. The smaller sac which lies anteriorly is empty but the posterior and larger is filled with an organized blood clot and has a shell-like wall which is partially calcified. The renal vein is not remarkable.

#### Microscopical Examination:

Section from the aneurysmal sac reveals a thickened hyalinized wall containing an atheromatous and calcified areas. Decalcification was necessary before sectioning. An old blood clot, without fibroblastic organization, is adherent to the intima. Sections from the kidney reveal a chronic inflammatory reaction with many collecting tubules filled with pus. There is interstitial fibrosis and invasion by many lymphocytes. The glomeruli are adequate in number and the tufts are large and congested. There is considerable cloudy swelling of the epithelium of the convoluted tubules.

#### Pathological Diagnosis:

Aneurysm, arteriosclerotic—renal artery. Pyelonephritis.  
/s/ O. WILDMAN,  
Commander (MC), U. S. Navy.

#### DISCUSSION

The patient presented none of the signs of aneurism such as pain, swelling, pulsation or hematuria, except the first, and that in no proportion to the lesion.

Of the three causes of aneurism mentioned in the order of their incidence, trauma, arteriosclerosis and syphilis, this one was due to the second. Aneurism by x-ray may have two appearances, a more or less bizarre filling defect of the pelvis simulating papillary tumor (Loughnane) or the "wreath shadow" or "annular ring" mentioned by McKay, Mathe, Wesson, and Fulmer, McClelland and others.

We wish to call attention to the fact that while all calcified aneurisms may not present it, in our case, and the illustrations of the cases of Mathe, Renke, Wesson and Fulmer, McKay, McClelland and Child, there is a defect in the calcified ring, probably the connection between the aneurism and artery. This ring with a defect may be of value in the differential diagnosis of aneurism and other calcified masses. That it is spherical and hollow should differentiate it from calcified glands. Another fact that may be valuable in differentiating aneurism from cyst is that it is outside the parenchyma as demonstrated by stercoscopy plates (Fig. 1) although in the pyelo-

grams it appears to be in the medial lower portion of the upper pole. (Fig. 2.)

If aneurism is found, nephrectomy is indicated. We suggest that if aneurism is considered in the diagnosis that surgical measures such as an extra wide incision be made to facilitate exposure, as the sclerotic vessels may break on ligation.

It should be mentioned that this patient's hypertension did not improve after nephrectomy.

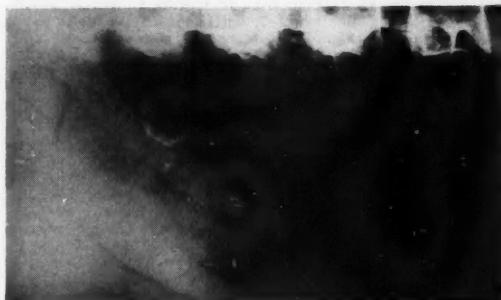


Fig. 1.—The renal shadow has been inked in to facilitate photography.

The position of the aneurism is not within the kidney substance.

Note the defect in the ring.

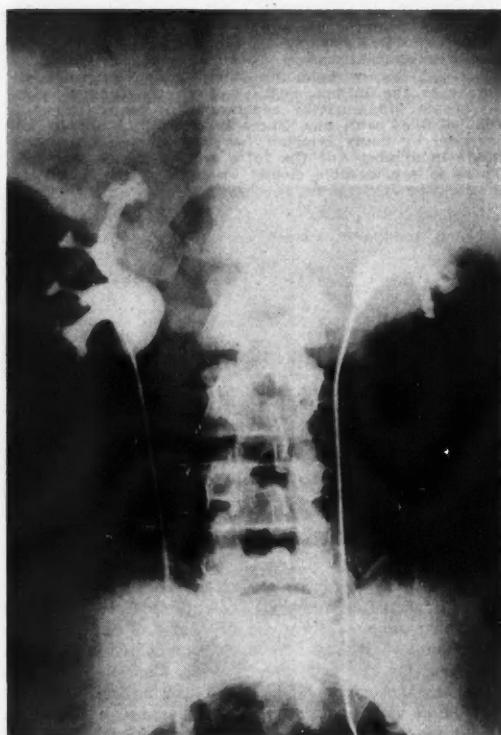


Fig. 2.—Pyelogram showing blunting and elongation of the upper calyx.

Note the incomplete ring shadow, and its relation to the pelvis.

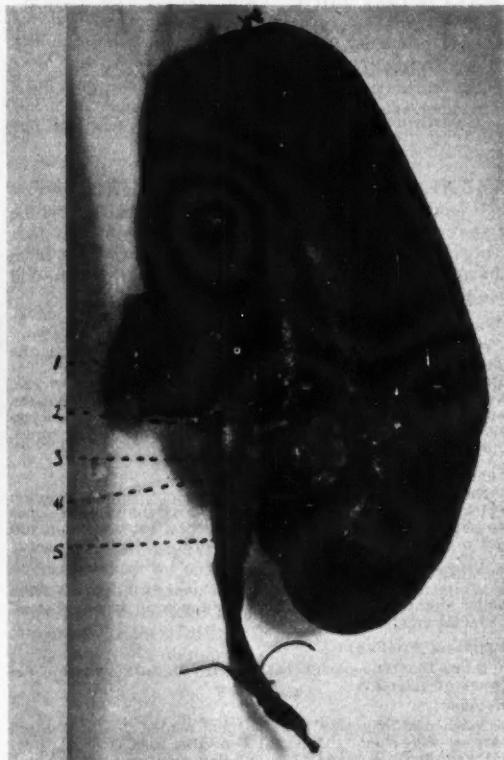


Fig. 3.—(1) the larger calcified aneurismal sac.  
 (2) Anterior portion of the renal artery with the superior and inferior divisions.  
 (3) The first portion of the posterior divisions of the renal A.  
 (4) Smaller aneurismal sac.  
 (5) Ureter.

#### SUMMARY

1. A case is reported of calcified aneurism of the left renal artery, due to arteriosclerosis.
2. Attention is again called to the broken-ring shadow that may be typical of calcified aneurism.
3. The hypertension did not improve after nephrectomy.

J. S. H., 700 C Street, Coronado.

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2. Brinkman, J. S.: J. Iowa M. Soc. 24 (Feb.), 1924. (1 case.)
3. Wesson and Fulmer: Am. J. Roentgenol. 33 (Feb.), 1935. (1 case.)
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5. Loughnane, E. L.: Brit. J. Urology 8 (June), 1936. (3 cases.)
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# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

## CALIFORNIA MEDICAL ASSOCIATION<sup>†</sup>

PHILIP K. GILMAN, M.D. .... President  
SAM J. McCLENDON, M.D. .... President-Elect  
E. VINCENT ASKEY, M.D. .... Speaker  
LEWIS A. ALESEN, M.D. .... Vice-Speaker  
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GEORGE H. KRESS, M.D. .... Secretary-Treasurer and Editor  
JOHN HUNTON .... Executive Secretary

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<sup>†</sup> For complete roster of officers, see advertising pages 2, 4, and 6.

### 75TH ANNUAL SESSION California Medical Association AT LOS ANGELES

Tuesday, May 7 - Friday, May 10, 1946  
Make note of these dates on your Calendar.

Scientific Programs and Official Reports will  
appear in April issue of C. and W. M.

The official headquarters of the next annual session of the California Medical Association to be held at Los Angeles, Tuesday, May 7 through Friday noon, May 10, 1946, will be the *Hotel Biltmore*, 515 South Olive Street (Olive, between Fifth and Sixth Streets), Los Angeles. Because of postwar conditions and prospective attendance, the facilities of other hotels must also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

#### LOS ANGELES HOTELS: WITH TELEPHONE NUMBERS

A list of some hotels in Los Angeles within easy distance of the Hotel Biltmore follows:

Hotels	Telephones
Alexandria Hotel, 210 W. Fifth St....	(MAdison 2741)
Ambassador Hotel, 3400 Wilshire Blvd....	(DRexel 7011)
BILTMORE HOTEL, 515 S. Olive.....	(MICHigan 1011)
Carlton Hotel, 519 S. Figueroa St.....	(MICHigan 6571)
Chapman Park Hotel, 516 S. Alexandria Ave.	
.....	(FItzroy 1181)
Clark Hotel, 426 S. Hill St.....	(MICHigan 4121)
Gates Hotel, 831 W. Sixth St.....	(TRinity 3931)
Hayward Hotel, 206 W. Sixth St.....	(MICHigan 5151)
Mayfair Hotel, 1256 W. Seventh St.....	(FItzroy 4161)
Mayflower Hotel, 535 S. Grand Ave....	(MICHigan 1331)
San Carlos Hotel, 507 W. Fifth St.....	(MUTual 2291)
Savoy Hotel, 601 W. Sixth St.....	(MAdison 1411)
Stillwell Hotel, 838 S. Grand Ave.....	(TRinity 1151)
Town House, 639 S. Commonwealth Ave.	
.....	(EXposition 1234)
William Penn Hotel, 2208 W. Eighth St.	
.....	(EXposition 3181)

### A.M.A. Session

American Medical Association will hold its annual session this year in San Francisco. Dates: Monday, July 1 - Friday, July 5, 1946.

## OFFICIAL NOTICES

## Announcements of California Procurement and Assignment for Physicians

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, February 25, 1946.

C.M.A. Component County Societies, Addressed.

Dear Doctors:

Under date of February 14, 1946, Procurement and Assignment Service for California Physicians issued a directive discontinuing from classification all physicians.

\* \* \*

A copy of the directive of February 14 (I), addressed to all County committees is enclosed herewith for your information.

Also find enclosed copy of a Press Release dated February 19 (II), in re: P. and A. for California Physicians.

Very truly yours,

PHILIP K. GILMAN, M.D., President,  
GEORGE H. KRESS, M.D., Secretary.

\* \* \*

(I)

(COPY)

FEDERAL SECURITY AGENCY  
Procurement and Assignment Service  
For Physicians  
Room 1422, 450 Sutter Street  
San Francisco 8, California

February 14, 1946.

To: County Committee of Procurement and Assignment Service

From: Harold A. Fletcher M.D., California State Chairman for Physicians' Procurement and Assignment Service.

Subject: Discontinuance Classification of Physicians.

On advice from the Central Board of Procurement and Assignment Service, there will be no further classification of physicians by the State Chairmen of Procurement and Assignment Service. My interpretation of this is that previous classifications of physicians as to essentiality or nonessentiality are void.

As this office is receiving continual inquiries for places to locate, I would appreciate it if county committees would keep me informed as to any community needs so that physicians may be referred to such locations.

The Procurement and Assignment Service program will probably be discontinued in the very near future but I would appreciate the county committees still remaining active until final notice is given.

\* \* \*

(II)

Press Release—Re: California Procurement and Assignment for Physicians

(COPY)

February 19, 1946.

This is a release by the California State Chairman of Procurement and Assignment Service for Physicians, Doctor Harold A. Fletcher, for all San Francisco newspapers, the Associated Press and the United Press.

\* \* \*

A directive discontinuing the practice of classifying physicians as Essential or Non-essential has been received from the Central Board of Procurement and Assignment Service in Washington by the California State Chairman of Procurement and Assignment Service for Physicians. These instructions have been forwarded to all county committees of Procurement and Assignment Serv-

ice of California. All previous classifications given to physicians have, therefore, been declared null and void.

The Procurement and Assignment Service was essentially a Selective Service for physicians. The medical profession itself was given responsibility for its success.

The medical, dental and nursing professions were the only groups which were honored with this responsibility during the war. The physicians of California have done an outstanding job not only in meeting the needs of the military forces but also on the home front. They have backed the Procurement and Assignment Service program almost 100 per cent, with the results that they have sent their utmost quotas of physicians to the war and, at the same time, have maintained a reasonably safe margin of medical care reasonably distributed here in California. The records show that no other state has done a better job.

California has fully made the quotas asked for by the military forces and we have never allowed our civilian supply of physicians to go below the level of safety set up on a state basis. The records show that, at the peak of enlistments in 1944, California had one physician to each 1,224 civilian population. The margin of safety is set one physician to 1,500 population. Some states allowed their ratio to sink as low as one to 2,200 on a state level. Other states, comparable to California in population, did not meet their quotas for the military forces and were over supplied with physicians on the basis set up for the emergency. Local shortages in California have occurred in various towns and communities due to rapid unforeseen expansion or often due to the deaths and disabilities of overworked physicians. These shortages were corrected as rapidly as possible and this could only have been done through the utmost cooperation of the medical profession.

The work of the Procurement and Assignment Service will soon be completed. The only remaining problems are the continuing relocation of veteran physicians and the reconversion of the teaching hospitals and medical schools from the accelerated wartime program to normal peacetime service.

I wish to publicly thank the medical profession of California for its loyalty, confidence and co-operation in a job well done.

## COUNTY SOCIETIES†

## CHANGES IN MEMBERSHIP

## New Members (5)

Los Angeles (1)

Langan, Arthur J., Los Angeles

San Francisco County (1)

Bergeron, W. Loret, San Francisco

Santa Barbara County (2)

Creek, Dale W., Santa Barbara

King, Frederick W., Santa Barbara

Sonoma County (1)

King, Louise Smith, Eldridge

## Transfers (9)

Alexander, Elmo, from Stanislaus County to Lassen-Plumas-Modoc County

Bockrath, Henry M., from Sacramento County to San Francisco County

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Boudett, D. W., from *San Francisco County* to *San Mateo County*  
 Clarke, Robert W., from *San Joaquin County* to *San Francisco County*  
 Hatch, Francis N., from *San Mateo County* to *San Francisco County*  
 Hazel, J. K., from *San Francisco County* to *San Mateo County*  
 Tuschka, Otto, from *San Francisco County* to *Fresno County*  
 Weizer, E. A., from *Stanislaus County* to *Santa Cruz County*  
 Wynns, Harlin, from *Alameda County* to *San Mateo County*

#### Retired Members (16)

Allen, Orah Knapp, *San Francisco County*  
 Barber, Edna M., *Alameda County*  
 Black, Emil C., *San Diego County*  
 Condit, John C., *Alameda County*  
 Fernandez, M. L., *Contra Costa County*  
 Hamilton, James K., Jr., *Alameda County*  
 Hart, Aden C., *Sacramento County*  
 Johnson, Murray L., *Alameda County*  
 Keser, Marguerite D., *Contra Costa County*  
 Kilbourne, Edwin D., *Santa Clara County*  
 Kruse, Frieda L., *San Francisco County*  
 Snure, Henry, *Los Angeles County*  
 Stephens, William B., *Alameda County*  
 Torrey, Harry B., *Alameda County*  
 Wayte, Edwin W., *Los Angeles County*  
 Wilmar, Alvin H., *San Luis Obispo County*

#### Life Members (2)

Fairchild, Fred R., *Yolo County*  
 A. M. Henderson, *Sacramento County*

#### Resignations (13)

Cutting, Windsor C., *San Mateo County*  
 Eliason, P. W., *San Mateo County*  
 Easton, Daniel E. F., *San Francisco County*  
 Eaton, Avis C., *San Francisco County*  
 Fritschen, William, *San Francisco County*  
 Gray, Horace, *San Francisco County*  
 Honigbaum, Max, *San Francisco County*  
 Layman, Mary H., *San Francisco County*  
 Maximov, Gregory M., *San Francisco County*  
 Piscitelli, Angela M., *San Francisco County*  
 Richli, Elmira M., *San Francisco County*  
 Selzer, Jadwiga, *San Francisco County*  
 Woelz, Emily, *San Francisco County*

## In Memoriam

**Bingaman, Elmer Wiley.** Died at Salinas, January 14, 1946, age 63. Graduate of the University of California Medical School, Berkeley-San Francisco, 1907. Licensed in California in 1907. Doctor Bingaman was a member of the Monterey County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Bryan, Lloyd.** Died at San Francisco, December 21, 1945, age 62. Graduate of the University of California Medical School, Berkeley-San Francisco, 1911. Licensed in California in 1911. Doctor Bryan was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Dameron, John Dysart.** Died at Stockton, September 25, 1945, age 77. Graduate of the Missouri Medical College, St. Louis, 1894. Licensed in California in 1895. Doctor Dameron was a Retired Member of the San Joaquin County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.



**Doran, Alexander Vincent.** Died at San Francisco, January 28, 1946, age 64. Graduate of the University of California Medical School, Berkeley-San Francisco, 1906. Licensed in California in 1906. Doctor Doran was a member of the Solano County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Downing, Samuel Robert.** Died at Berkeley, January 19, 1946, age 63. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1915. Licensed in California in 1915. Doctor Downing was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Eastman, William Russell.** Died at La Jolla, December 28, 1945, age 72. Graduate of George Washington University School of Medicine, Washington, D. C., 1901. Licensed in California in 1923. Doctor Eastman was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Gilbert, William Henry.** Died at Los Angeles, February 3, 1946, age 78. Graduate of Bellevue Hospital Medical College, New York, 1889. Licensed in California in 1914. Doctor Gilbert was a Retired Member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.



**Gius, Enea Augusto.** Died at San Francisco, January 4, 1946, age 53. Graduate of Regia Universita degli Studi di Firenze, Facolta di Medicina Chirurgia, 1921. Licensed in California in 1923. Doctor Gius was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Gregory, Hunter Lee.** Died at Stockton, November 10, 1945, age 58. Graduate of the Medical College of Virginia, Richmond, 1915. Licensed in California in 1920. Doctor Gregory was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Lamson, Robert Ward.** Died at Tujunga, December 31, 1945, age 56. Graduate of Harvard Medical School, Boston, 1925. Licensed in California in 1925. Doctor Lamson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Pierson, Philip Hale.** Died at San Francisco, January 17, 1946, age 59. Graduate of Harvard Medical School, Boston, 1913. Licensed in California in 1915. Doctor Pierson was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Turner, Eldridge Curts.** Died at Sacramento, February 10, 1946, age 62. Graduate of the University of California Medical School, Berkeley-San Francisco, 1905. Licensed in California in 1905. Doctor Turner was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

**White, Alfred Stevenson.** (Lieutenant Colonel, Army of the United States). Died at San Francisco, February 13, 1946, age 38. Graduate of the University of California Medical School, Berkeley-San Francisco, 1932. Licensed in California in 1932. Doctor White was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

## COMMITTEE ON ORGANIZATION AND MEMBERSHIP

### Membership Statistics of Some Larger County and State Medical Associations\*

County Society	No. of Members
I. New York:	
(a) Medical Society of the County of New York .....	5,802
(b) Medical Society of the County of Kings .....	3,135
(c) Bronx County Medical Society .....	1,558
(d) Medical Society of the County of Queens .....	1,219
(e) Medical Society of the County of Nassau .....	493
II. Chicago Medical Society (Cook County) .....	5,614
III. Los Angeles County Medical Association .....	3,400
(Plus several hundred on leave)	
IV. Wayne County Medical Society (Detroit) .....	2,146
(Associate Members—680)	
V. Philadelphia County Medical Society .....	2,800
VI. St. Louis Medical Society .....	1,235

Membership totals in the ten largest Constituent State Medical Associations (according to listing in *J.A.M.A.*, April 29, 1944, page 1261) follow:

1. New York .....	18,908
2. Pennsylvania .....	9,951
3. Illinois .....	8,623
4. California .....	7,550
5. Ohio .....	6,752
6. Massachusetts .....	5,528
7. Texas .....	4,607
8. Michigan .....	4,567
9. New Jersey .....	4,294
10. Indiana .....	3,397

Note. The above figures are only relative and do not indicate membership since V-J Day of year 1945.

### Section on General Practice Organized in the Los Angeles County Medical Association

The first meeting of the General Practice Section was a great success. Almost two hundred signed the register, and quite a number came in late so that the auditorium was crowded to the rear wall. It was very gratifying

to see quite a few of our friends from the various specialist sections scattered throughout the auditorium.

The meeting was called to order promptly at 8:00 p.m. and a brief statement was made by the chairman, problem regarding the purposes of the meeting and the hopes and anticipations. Dr. E. T. Remmen, secretary of the Association, stated briefly the action of the Council in authorizing the formation of the new Section, and added his very congenial words of encouragement and good wishes.

There seemed to be present right from the start a very friendly feeling throughout the audience. The entire meeting was very democratic in spirit. The chairman gave opportunity for members from the floor to express themselves regarding the formation of the new Section and to put forward any ideas they might have on organization.

After free discussion the following resolution was adopted unanimously:

"WHEREAS, The general practice of medicine is a branch of the healing art which should rank in all respects with other specialties, and is one which requires ability and training of the highest order on the part of its practitioners, along a broad and comprehensive, rather than a limited and specialized approach, and

"WHEREAS, A substantial number of members of the Los Angeles County Medical Association are engaged in general practice, and are desirous of extending their scientific and fraternal interests, and

"WHEREAS, The Council of the Los Angeles County Medical Association recently authorized the formation of a Section on General Practice.

Therefore be it Resolved, That we, general practitioners, members of the Los Angeles County Medical Association, do hereby constitute ourselves a Section on General Practice of the Los Angeles County Medical Association, and be it further

Resolved, That a Chairman, a Vice-Chairman, and a Secretary-Treasurer be elected forthwith, and that a Committee be selected to draft by-laws for consideration at the next meeting."

Officers were elected as follows: Dr. Eric A. Royston, Chairman; Dr. Francis R. McCrea of Long Beach, Vice-Chairman; Dr. H. Vern Soper, Secretary-Treasurer. It was voted unanimously that the Program Committee and the Committee on Constitution and By-Laws be appointed by the Chair.

The new little ship has been launched under ideal circumstances. Our sails are unfurled, and we are full of courage as we look towards the broad horizon.

### What of the future?

We have a very strong, vigorous Program Committee planning some most excellent meetings for us. These meetings will be held the last Thursday night of each month in the County Medical Association lounge. Any one who attends these meetings regularly will soon realize that he is getting a most excellent postgraduate refresher course delivered to him free of expense, and with no travel and hotel problem items to be considered.

Having organized our Section in Los Angeles County, we are now in a position to help some of the other County Associations with their organization. It will not be long before this new General Practice Section idea spreads throughout California, and we hope it will be only a few short months before we have a Section on General Practice in the State Association. It is surprising how many inquiries have come in by mail and by telephone.

Sail on, little ship, sail on and on and on!

ERIC A. ROYSTON, M.D., Chairman.

### Physicians for Rural Communities

#### U. S. Department of Agriculture Calls Attention Thereto

The agriculture department says the country doctors are fighting a losing battle for the health of rural America.

\*These membership totals of some of the larger County Medical Societies in the United States sent to Doctor Kress about January 10, 1946, by Doctor Olin West, A.M.A. Secretary. For editorial comment, see p. 115.

Their ranks, says the department, are not being adequately replenished by young, well-trained graduates from modern medical and dental schools.

As a consequence, adds the agency, rural areas—even with their sunlight and fresh air, freedom from industrial dust and fumes, absence of bustling crowds in which communicable diseases can be readily spread—are losing health advantages they once held over urban areas.

In a report on rural health conditions, the department says that because of the shortage of well-trained professional persons, thousands must depend for their medical services largely on untrained midwives, drug-store clerks or cultists.

The department offers rural communities some suggestions for going after some of the young doctors returning from the armed services and for educating future doctors.

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The scarcity of rural doctors is reflected by a survey showing that before the war in the thousand most rural and isolated counties of the nation there were so few medical men that each had to serve an average of 1,700 persons, while in the larger cities there was a doctor for each 650 persons.

During the war the rural average dropped as low as one doctor for 3,000 to 5,000 persons, because rural doctors almost everywhere exceeded their quotas in entering the armed forces.

Doctors and dentists, the report says, tend to shun rural counties because they feel they can make a better living in cities and have greater access to modern hospitals, technical equipment and professional contacts.

The rural shortage also reflects, the department says, a failure of many states to provide educational opportunities for doctors. It says that almost half of all young doctors now come from medical schools in five major industrial states, while 18 states, mostly rural, turn out no medical graduates from their schools.

Emphasizing the need for better health facilities, the report referred to the millions of American young men who were rejected by the armed services because they didn't measure up to military standards.

"Farm people," the report says, "should be more distressed than others because farm youth showed up considerably higher rejection rates than the average. . . . This is the opposite of the situation in the last war, so the health of rural youth is relatively going downhill."

Now that doctors and dentists are returning from war, the department feels that many rural communities could take steps to obtain practitioners. Such communities, it suggests, could offer a doctor an attractive house in which to live and an office in which to work.

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It suggests further that the community offer to provide a prospective doctor with technical equipment, pay his traveling and moving expenses and guarantee him a minimum income for the first year, such as \$4,000 to \$5,000. This could be done, it is suggested, by agreeing to make up, from county tax funds, any amount by which the income falls short of the guaranteed sum.

It says a rural community could advertise such offers in medical journals.

The department also suggests that rural residents in states without medical schools urge public officials to provide rural medical fellowships—that is, to arrange for the education of a number of medical students on the understanding that they set up practice in a rural community and remain there for five years or so. First preference for such scholarship would be given to country boys.

Another problem, says the department, is "outdated"

license laws which keep out physicians and dentists from other states.

License reciprocity could be extended much more among the states, says the department. Better still, it suggests, would be uniform license laws.

1 1 1

The department suggests also that the national social security system be broadened to provide health insurance for rural people.

"It would not be very difficult," the department says, "to include farm people in social security even though their contributions could seldom be handled through any kind of automatic deductions from wages or income."

Instead of making regular payments, the department suggests, the farmer could contribute once a year, when he pays his income tax, or he could be covered by a "stamp plan," with contributions paid at the postoffice and with receipts in the form of stamps kept in a small book.—San Diego *Union*, January 20.

#### Doctor-Veterans Are Admitted In Alameda

Alameda County's Medical Association has elected to membership every physician-veteran who has applied since the end of the war, regardless of his place of residence or place of practice before he entered the service.

A statement to that effect was released yesterday by Rollen Waterson, executive secretary of the Alameda county group, in answer to charges private medical agencies have banned the entry of "immigrant" physicians into medical practice in the Bay Area.

"There is no discrimination against any group or class of physicians who apply to the Alameda County Medical Association," Waterson declared.

"We reject only those inadequately trained or those shown to be unworthy of the public confidence."

First complaints on the local medical picture came from returning physician-veterans who charged that the doctors who remained out of service now were making it virtually impossible for others to practice.

The American Civil Liberties Union has lodged a formal protest in Washington against Dr. Harold A. Fletcher, State chairman of both the official Procurement and Assignment, and the Postwar Planning Commission of the California Medical Association.

The A.C.L.U. alleged unconstitutional discrimination is being applied to doctors desiring to "immigrate" to this area.—San Francisco *Chronicle*, February 13.

#### Red Cross Blood Donor Service—Los Angeles Chapter and Los Angeles County Medical Association

Following is a Memorandum of Understanding between the Los Angeles County Medical Association and the Los Angeles Chapter, American Red Cross.

The Los Angeles Chapter, American Red Cross, is to procure blood from volunteer donors for use in military and civilian hospitals throughout Los Angeles County, all expenses of procurement, typing, and delivery of blood to be financed by the Los Angeles Chapter, American Red Cross. No charge is to be made by any hospital or physician for the blood itself.

#### Technical Supervisor

A Technical Supervisor, who will serve in a volunteer and advisory capacity, is to be appointed by the County Medical Association.

#### Personnel

All technical personnel to be employed by the Red Cross must be approved by the County Medical Association.

#### Technique

Technical practices for the drawing of blood are to be approved by the County Medical Association.

#### Serology and Typing

The Red Cross will arrange for satisfactory typing of blood and have Kahn serology run on each donation.  
*Distribution*

Blood will be distributed by the Red Cross to hospitals, clinics, and physicians after their request for blood, and facilities for use, have been approved by the County Medical Association.

*Medical Care*

In event of injury or accident to a volunteer donor, the County Medical Association will make recommendation and arrange for medical care, expenses to be borne by the Red Cross.

*Blood Donor Committee*

The President of the Medical Association or other representative thereof will serve on the Volunteer Blood Donor Committee of the Los Angeles Chapter, American Red Cross.

LOUIS J. REGAN, M.D., *President, Los Angeles County Medical Association.*  
W. T. SESNON, JR., *Chairman, Los Angeles Chapter, American Red Cross.*

(The above was approved by the Council of the Los Angeles County Society at its meeting February 4.)

... The Council at its meeting November 5, 1945, acting upon the request of Mr. William T. Sesnon, Jr., Chairman of the Los Angeles Chapter of the American Red Cross, to approve of a free blood donor service for Los Angeles County; appointed a special committee with Doctor Howard Bosworth, Chairman, to meet with Red Cross officials to develop a satisfactory working agreement between the Los Angeles County Medical Association and the Los Angeles County Medical Association and the Los Angeles Chapter of the American Red Cross.

Doctor Regan presented a memorandum of understanding between the two organizations and requested Council action. (This memorandum appears elsewhere in this issue.)

Upon motion duly made and seconded, the above memorandum was ordered approved. However, the special committee was requested by the Council to ask the Red Cross to be guarded in public utterances relative to this donor service, especially in news releases indicating that blood was available to all physicians; it being the belief of the Council that blood should be available only when it was to be administered in institutions with adequate facilities. . . .

**Alameda County Medical Association Plans Assistance For Returning Doctors**

A program of assistance for doctors returning from the armed services has been organized by the Alameda County Medical Association.

To build a fund for this program, physicians who remained out of service have increased their association dues and made other contributions. A portion of this fund has been utilized to employ a realtor to assist doctors in obtaining offices when reestablishing their practices.

Veterans are not required to pay dues for assessments of the Association, and all qualified physician-veterans who have applied have been elected to the Association, regardless of residence or place of practice before entering the Army or Navy.

The youth of America is their oldest tradition. It has been going on now for three hundred years.

—Oscar Wilde, *"A Woman of No Importance, Act 4.*

We Americans are children of the crucible.

—Theodore Roosevelt, *Speech, 9 Sept., 1917.*

## COMMITTEE ON HISTORY

### Los Angeles County Medical Association's Diamond Jubilee

The *Bulletin* of the Los Angeles County Medical Association, in its issue of February 21, 1946, gave the following account of its 75th anniversary dinner: Thursday evening, January 31, the Los Angeles County Medical Association ended its seventy-fifth year with a Diamond Jubilee Banquet at the Biltmore Bowl.

Nearly nine hundred—members and wives and friends and guests of the Association, including the officers and councilors of the California Medical Association—took part in the festivities.

Dr. George H. Kress, secretary-treasurer of the State Association and editor of CALIFORNIA AND WESTERN MEDICINE, was master of ceremonies. Dr. Kress was asked to serve in that capacity because of his many years of membership in the Los Angeles County Medical Association. Dr. Kress became a member in 1904 and for nine years served as secretary. His knowledge of the history and growth of the Association is not exceeded by any member.

Dr. Kress, after touching on a few highlights of the Association's history, introduced the official family of the California Medical Association and the officers and trustees and councilors of the Los Angeles County Medical Association.

Brought to the rostrum for a special introduction were: Lula Talbot Ellis, M.D., who joined the Association in 1889, and served as its secretary for the years 1892 to and including 1895. Dr. Ellis, now retired from the active practice of medicine, has retained her active membership status for fifty-seven years, a record that few associations or members can claim.

Dr. Francis M. Pottenger, Sr., who joined the Association in 1901, and served as its president in 1907.

Dr. Raymond G. Taylor, who joined in 1899 and served as secretary during the years 1905, 1906 and 1907.

Dr. William R. Molony, Sr., who joined in 1903 and served as President in 1932, and who recently has been honored by being elected Vice-President of the American Medical Association.

Doctors Philip K. Gilman of San Francisco, President, and Samuel J. McClelland, President-Elect, of the California Medical Association, and Dr. E. T. Remmen, Secretary-Treasurer of the Los Angeles County Medical Association, made brief addresses.

The Bowl floor show and dancing completed the program.

The Anniversary issue of *The Bulletin*—a history of the Association—made its debut at the banquet. Copies of this issue have been mailed to all members, to medical libraries and to officers of numerous medical societies.

### Diamond Anniversary of the Los Angeles County Medical Association—Historical Notes

The 75th Anniversary Dinner to celebrate the founding of the Los Angeles County Medical Association was held in the Bowl of the Hotel Biltmore in Los Angeles on the evening of Thursday, January 31st, some nine hundred being in attendance.

The excerpt from the *Bulletin of the Los Angeles County Medical Association* appearing above outlines briefly the proceedings on this historic occasion.

Here additional reference may be made to the motivating spirit among the seven founders, the late Joseph Pomeroy Widney, who also founded the College of Medicine of the University of Southern California; later becoming President of University of Southern California, and protecting that institution from bankruptcy proceedings, through advancement of his own personal collateral.



Officers of the Los Angeles County Medical Association: (left to right) Louis J. Regan, M.D., President; Philip Stephens, M.D., Chairman, Board of Trustees; E. T. Remmen, M.D., Secretary-Treasurer (standing); C. Max Anderson, M.D., Vice-President.

The Diamond Anniversary celebration of the founding of the Los Angeles County Medical Association may be said to have been a brain-child of its present secretary, Doctor E. T. Remmen; to whom credit must also be given for the 200 page 75th Anniversary Number of the *Bulletin of the Los Angeles County Medical Association*, in which will be found the story of the development of a component county unit that is today the third largest county medical society in the United States; also being exceeded in membership number by only some nine of the constituent state medical associations of the American Medical Association. (Statistics on page 136.)

When Secretary Remmen was called upon for remarks at the anniversary dinner, he limited himself to a recital of the graduating address given by Founder Widney to the first graduating class of the College of Medicine of the University of Southern California.

The character of Dr. Widney is excellently portrayed in this address to his first graduating class and appears below.

Also for historical purposes, comments made in CALIFORNIA AND WESTERN MEDICINE for August, 1938, to call attention to the passing of Dr. Joseph Pomeroy Widney are given.

Quotations follow:

FOUNDER WIDNEY'S ADDRESS TO THE FIRST GRADUATING CLASS OF COLLEGE OF MEDICINE, U.S.C. (YEAR 1888)

#### *My Students:*

*Other men go out from the college classroom to enter upon the stir and bustle of the vigorous life of the world. They go as well men among the well. You go out to the byways of life; to a daily companionship with the crippled, the diseased, the suffering. As you go, some things I would that you should ever bear in mind:*

*Learn to be patient. Poor broken humanity, in its weakness and its pain, will tax your patience often and again. But remember that it is poor and broken, and that you are to come to it in its impatience and suffering, like Him of old, as a healer. Be very patient and very gentle; remember the infinite patience, and the infinite gentleness of the "seventy times seven."*

*Be sympathetic. Harshness has no place in the sick room. Let your daily visit be to the sufferer as a daily benediction. Be of pure, clean lives. You are to enter into the homes and the lives of men as can no other. Not even the minister or the priest can so reach the inner lives of humanity. You are to bear its secrets, to know its frailties, often indeed to be its conscience. How shall you be a true healer of men, a healer of souls as well as bodies, if your own lives are full of uncleanness and sin?*

*Be strong! Strong to carry the burden of humanity in the hours of its extremity; strong to resist its pleadings in the hour when, with soul laid bare, it would persuade you to use your skill to hide sin. For two souls are at*

stake—the soul of the one who so pitifully pleads, and your own soul.

And so, when the last sick call shall have been answered, and the last prescription written, and the tired fingers for the last time lay down the pen, shall you wrap the drapery of your couch about you as one who lies down to pleasant dreams; and so shall you pass down to the valley of the shadow, fearing no evils.

And so shall you not dread to meet the face of the Master, who was also a healer of men.

\* \* \*

ON THE PASSING OF JOSEPH P. WIDNEY, FOUNDER OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION

*Excerpts from C. and W. M., August, 1938*

To have lived to the ripe old age of 97, with a mind keen and alert up to its last hours, despite such physical handicaps as a frail body and practical blindness, is an experience that has not often come to human beings. Yet such was the life of Dr. Joseph Pomeroy Widney,\* whose death took place at Los Angeles on July 4, 1938.

\* Biographical sketches of the late Dr. Joseph Pomeroy Widney appeared in CALIFORNIA AND WESTERN MEDICINE in the following issues: Vol. 44, No. 4, April, 1936, page 292; Vol. 44, No. 5, May, 1936, page 296; Vol. 46, No. 6, June, 1937, page 398; Vol. 49, No. 2, Aug., 1938, pp. 106 and 161.

Doctor Widney, it will be recalled, was the motivating spirit in the founders group which organized the Los Angeles County Medical Association on January 31, 1871, some sixty-seven years ago, and he—who in recent years was the oldest living graduate of the University of California (having received his M. D. degree from Toland Medical College in 1866)—also founded the College of Medicine of the University of Southern California in the year 1885. Later, in the financial panic of the nineties, he resigned as dean of the University of Southern California Medical Department in order to take over the responsibility of saving the University of Southern California at a time when its properties were about to be levied on by the courts; guaranteeing with his personal resources as he assumed the presidency the payment of the claims pending against the institution.

Born in Ohio in 1841, so far back that he recalled a childhood amid the wigwams of Indians, a soldier in the War Between the States and an assistant surgeon in Indian campaigns in Arizona, while successful as a physician in private practice in Los Angeles, he became the founder of a county medical society that is today one of the largest in the United States. He was also founder and dean of a medical school, and president and protector and saviour of the University of Southern California in its early days of life and death struggle. As a civic worker he had a broad and far-seeing vision of railroad,



Master of Ceremonies and four of senior members of Los Angeles County Medical Association, selected for special honor. (Left to right) George H. Kress, M.D., Master of Ceremonies; Lula Talbot Ellis, M.D., Raymond T. Taylor, M.D., F. M. Pottenger, M.D., William R. Molony, M.D.

harbor and other developments, on a massive scale, for the southern section of California. Also minister of the gospel, and founder of a settlement house, and devotee of the gospel work, author of volumes of historical and other essays,<sup>†</sup> including a large two-volume "Race Life of the Aryan People," he proved himself a kindly philosopher, with a mind richly stored with knowledge of the past, and ever alert and inquiring as to the significance of current changes and events. Dr. Joseph Pomeroy Widney's life was indeed such as is granted to but few men to enjoy.

And so, once more, a great man has been gathered to his fathers.

The following two essays, "Why Is Death?" and "Heaven," both written by Doctor Widney a few days before his death, at age 97, are printed *In Memoriam* to a beloved physician, whose name the California Medical Association may well place on its honor roll, and for all time to come.<sup>†</sup>

#### WHY IS DEATH?

Across the pathway of life, and apparently bringing it to an end, is Death, and from the earliest antiquity men have been asking the question, "Why death at all?" "Does it serve any useful purpose in the Drama of Life?" The answer is Yes, without death the drama of life would be a failure. The purpose of that drama is—The Making of a Man: not simply for time, but for eternity. That making is what has been called Evolution. Through all the years of his life man has been growing. It is the law of evolution, that is, of growth. The planet grows. It is first a gaseous nebula. It then becomes a habitable world. The man's body through which he works is a necessary attendant upon that life. A man may will that a brick shall place itself at a certain point in a wall which he is building—it does not obey. But he may will that hand to take that brick and put it into its proper place. It is a matter acting upon matter through the use of matter. It is so in all phenomena of life. The subtle and intangible will of the spirit has acted upon matter. But in this circuitous way, man realizes that he is hampered and restricted in his work.

Man is restricted in his knowledge of the world about him. He had thought that the seven prismatic colors were all. By using the chemical paper, he now knows there is an infra-red and an ultra-violet which he does not see. It is so in every department of human inquiry. It is so in the pitch, in the low and the high notes in music, and it is so in all the broad field of strange, intangible rays of power and light that come to us from the universe about us.

Shall man be stopped in his intellectual evolution by the limited range of the possibilities of further investigations in the universe about him, because of the material limitations of the body through which, in this life, he must work? There is no escape from these limitations unless he is released from the body which defines them. This is why Death! Death is simply *release* that men may go on.

This is what every religion tries to explain. Man set free from the shackles that impede his progress that he may go on. It is not a calamity. It is a blessing in disguise. It is like the blessing of toil placed upon primitive man that he might work and progress.

The idle man in Paradise had failed. The man who went out from Eden to toil with the briars and brambles of a fertile earth that he might have food succeeded.

But the time comes when a man, even with all his achievements, reaches the limit. He can go no farther in a lifetime. Is his progress to cease? Death in this life has answered the question. Death is not a calamity! Man may still go on; Death may be the sum total of his experiences. It is the greatest blessing to man that God has made. Die—and go on!

Is this death to be all or does Eternity hold other deaths yet to come?

We deem that this life is not all, but is only one stage in the evolution of man upon earth. Eternal life upon this planet is withheld from man. The story is thus told in Genesis III, Verses 22, 23, 24.

(22) "And the Lord God said, Behold, the man is become as one of us, to know good and evil: and now, lest he put forth his hand and take also of the tree of life, and eat, and live forever:

(23) "Therefore the Lord God sent him forth from the garden of Eden, to till the ground from whence he was taken.

(24) "So he drove out the man: and he placed at the East of the Garden of Eden Cherubim, and a flaming sword which turned every way, to guard the way of the tree of life."

Eternal life upon earth—do we realize what it would mean? The body grows old—it has worn out its material envelope. Age, and a life properly lived, brings with it maturity. After maturity there follows decay.

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#### HEAVEN\*

Heaven—What is it?—When?—Where?

What conclusions must we draw from the many beliefs of the ancient and modern writers? Only one conclusion will be possible, that we are mistaken utterly in the meaning of the word Heaven. Everywhere in the Universe we find the law of eternal growth and eternal deterioration. It seems to be the same in every department of the Universe—material, intellectual, and spiritual. The pleasures of heaven lie in the thought:

I, too, am a sharer in the development of the worlds about me, a sharer with God, therefore forever sharing in the mind of the Supreme Maker of the Law. Was this not the deeper meaning of the word spoken by the Supreme Ruler—when discussing the future of man upon earth, "He will become as one of us—knowing good and evil"? The thought is, if in this lower sphere man should eat of the tree of life and live and gain eternal life, would it be death to his soul?

Life as we know it upon this plane is to be lived by successive births and consequent deaths; the soul progressing and developing in accordance with the fixed and unchanging law spoken in the beginning.

## COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

### Governor Warren Signs Bill for U.C.L.A. Medical School

Sacramento Feb. 19.—Governor Earl Warren today signed the Davis bill appropriating \$7,000,000 to establish a medical school at the Los Angeles campus of the University of California.

"I don't know of any appropriation bill before me that would give me more satisfaction to sign than this one," the Governor said.

Standing about him in the executive office were members of the Legislature who had a hand in pushing the bill through, as well as a group of doctors, including Drs. Rupert Rainey, Harry Friedgood, Myron Prinzenmetal, Wilbur Bailey and Elmer Belt, all of Los Angeles.

#### Warren Statement

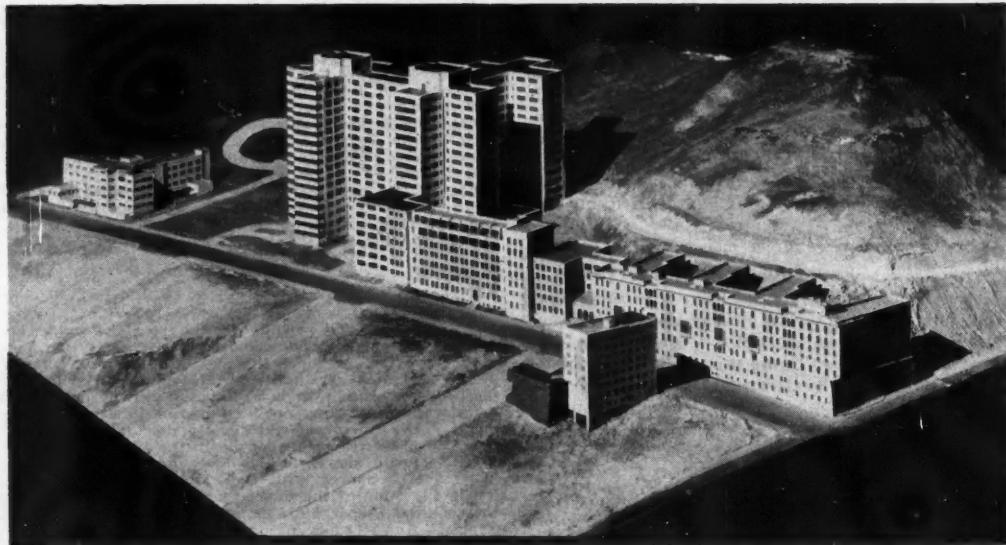
"I believe we can do as much good for the people of the State in this manner as any way of spending the money," Warren said. "I hope we can get this center under way quickly and that it will become one of the great medical centers of the country."

He thanked Dr. Belt for what he termed "the education" the doctor had given him last summer on the urgent need for a medical training center at the university in Los Angeles.

Others attending the ceremonies were Charles Lyon, Speaker of the Assembly; James Corely, controller of the university; Assemblyman Phil Davis, in whose district U.C.L.A. is located; State Sen. Jack Tenney, and Assemblyman Ralph Dills, chairman of the Los Angeles County delegation.—*Los Angeles Times*, February 20.

\* Doctor Widney was the author of the following volumes: "Race Life of the Aryan Peoples," "The Lure of the Land," "Three Americans," "A Greater Los Angeles," "A New Europe," "A New Orient," "Studies of Other Worlds."

\* This essay was dictated by Dr. Joseph P. Widney on June 29, 1938, his death occurring five days later, on July 4, 1938.



Photograph, through courtesy of Mr. Timothy L. Pflueger, architect of new buildings for University of California Medical School in Medical Center at San Francisco. The large group in the center is the new Teaching Hospital and the Sciences Building (to be erected), and immediately in front of that is a low structure which is part of the Sciences Building. Just to the right of the Sciences Building is the existing Clinic Building, then the present Hospital, and immediately in front of the present Hospital is the existing Nurses Home. In the distance, to the left, is the Langley Porter Clinic.

### U. C. Hospital and Medical School in San Francisco Plans "Finest Plant" With Fund

The four million dollars appropriated by the Legislature for the University of California Hospital at Third and Parnassus avenues is only part of the money needed to complete the long-range plans for the medical school and hospital. (For editorial comment, see page 118.)

Two new large buildings are planned, a medical science school to replace the old red brick building dating back to the 19th century and a new and modern teaching patient hospital.

The present hospital building would be used exclusively for private patients.

The university, like all medical schools, must provide facilities for private practice to attract the caliber of physicians and surgeons that are necessary for a top-rank school.

Architect Timothy Pflueger is preparing plans for buildings which will each be "18 or 20 stories high." He said construction will begin sometime in 1946 and the project will be finished in a few years. "It should give the U. C. Medical School one of the finest plants in the United States—and that means the world," according to Superintendent S. F. Durie.

The superintendent said the chief problem was to sandwich in the new buildings on the hilltop campus here, without interfering with the continued use of the old ones.—*San Francisco News*, February 7.

### Comment on Special Session of California Legislature

After mixing good and evil, the special session of the Legislature has adjourned. It appropriated more than a quarter of a billion dollars. . . .

It did several things which meet with general approval. It broadened the base of aid to veterans and refurbished the veterans' code. It appropriated \$154,000,000 for a State institutions building program, which was correct under the principle that State interests are first, as was

its Federal fund-matching appropriation for flood control. It made possible a medical school and center at the University of California at Los Angeles, filling a need that was not debatable. It made other desirable appropriations in the general interest of the State, but spoiled its good record here by letting die the bill to aid poor school districts. This was a necessary measure and its demise is deplorable. . . .—Excerpt from editorial, *Los Angeles Times*, February 21.

### Educator Warns on Keeping Young Physicians in Military Services

In Chicago, on February 11, a prominent medical educator asserted high American medical standards might be "compromised" by keeping young physicians in the Army and Navy too long. Dr. Perrin H. Long, director of the department of preventive medicine at Johns Hopkins University, expressed this view in a talk prepared for the forty-second annual congress on medical education and licensure.

"The selection of the bulk of young medical men in this country for service in the armed forces interrupts this program and transfers these individuals to the relatively limited sterile fields of military medicine, at a time in their careers when their seeds of productivity in medical research normally begin to sprout," said Long.

"Present standards of American medicine will be compromised unless these young men are returned to the laboratories and clinics of this country within a reasonable period."

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Dr. Wilbert C. Davidson, dean of the Duke University medical school, asserted a tour of European medical schools and clinics convinced him medical education abroad "is not as good as most physicians formerly thought."

"It has been profoundly affected by the war, both by the mental restrictions of the German occupation as well

as by the actual physical destruction in Great Britain, France, Italy and Germany."

"The United States today is the medical center of the world," asserted Dr. George F. Lull, associate general manager of the American Medical Association in Chicago, and formerly deputy surgeon general, United States Medical Corps.

"Better medicine is being taught and practiced in this country than in any other place."

Dr. Ray Lyman Wilbur of Stanford University, chairman of the American Medical Association's council on medical education and hospitals, joint sponsor of the congress with the Federation of State Medical Boards, praised American medical colleges.

Their graduates, he said, during the last 25 years have done "the best practical job in medical care and public health that has ever been done in the history of the world."

## CALIFORNIA PHYSICIANS' SERVICE†

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### Executive Staff

W. M. Bowman, Executive Director  
 A. E. Larsen, M.D., Medical Director  
 W. H. Gardenier, M.D., Assistant Medical Director

On February 2nd, the Board of Trustees of California Physicians' Service held a joint meeting with the Fee Schedule Committee, for the purpose of reviewing certain items where there was a difference of opinion as to the proper fee.

After a thorough review of these items, and considerable discussion, agreement was reached on all items with the exception of the section on Radiology. Inasmuch as it was impossible for a representative of this section to appear at any of the hearings, it was suggested that this phase of the schedule be referred to the Pacific Coast Roentgen Society for immediate action.

On February 3rd, the Board of Trustees held a regular meeting.

Legal Counsel reported that in the case of C.P.S. vs. the Insurance Commissioner, the case had been argued orally in the Supreme Court, and a decision may be expected within three or four months.

The board unanimously approved holding the Annual Meeting of Administrative Members in conjunction with the meeting of the House of Delegates of the C.M.A.

On Acquisition for December, Mr. Bowman reported a total enrollment of 14,141 persons—4,401 in the North and 9,740 in the South. Total beneficiary membership is approximately 182,300.

Dr. Larsen reported enrollment of 155 new professional

members in December. Total professional membership is now 5,897. During the month, 165 member physicians reported returning from military service, and were sent current information on C.P.S. and its operations.

Dr. Cooley reported that he and Mr. Bowman attended the meeting of the Sacramento County Society for Medical Improvement on January 15th. Most of the complaints presented in the report of that Society some months back have been corrected. Since that meeting, some 60 doctors have affirmed or re-affirmed their support of C.P.S., and there are now more than 70 doctors in Sacramento county willing to render service to C.P.S. beneficiary members.

A letter from Hospital Service of Southern California, requesting the discontinuance of the San Diego District Office, was presented. After considerable discussion, the board voted that this office should be maintained by C.P.S.

In connection with financial reports distributed to the trustees, Mr. Bowman reported that the Commercial Program deficit has been reduced from \$259,000 to \$196,000 and the reduction should continue at the rate of from \$25,000 to \$35,000 a month. The rate increase is 97 per cent complete. Administrative expense for the past five months has been 17.9 per cent. Mr. Ralph R. Nelson, actuary, is reviewing recent statistical material, and will furnish a report to the board.

Dr. Larsen reported that the liquidation of the Housing Program, completed January 1st, proceeded very smoothly, with excellent reaction in the communities affected.

On the Rural Program, after discussion with Regional Officers of the Farm Security Administration, it has been agreed that when contracts with the individual Farmers' Health Associations expire, the members will be transferred into the regular surgical and hospital coverage under the Commercial Program. The Grange Program is starting shortly, and the first meeting with a Grange Group will be held in February. This will mean that coverage will be available to any farm group, but that C.P.S. will be operating under its Commercial Program only, at one unit value, and with just two contracts—the medical and the surgical. It is felt that this will meet with the whole-hearted approval of the profession and the rural population of the State.

In answer to a question from Dr. Doughty concerning the enrollment of doctors who had been in military service as beneficiary members, together with their families and employees, Mr. Bowman stated that there would be a re-opening in March.

Dr. Cooley and Mr. Bowman reported their recent visit to Montana, for a special meeting of their House of Delegates at which time Montana Physicians' Service was organized. C.P.S. is furnishing advice and assistance, but neither C.P.S. nor the C.M.A. will incur any expense. New Mexico and Nevada have also asked for assistance in setting up prepaid care plans, and Arizona has expressed an interest.

Developments in the field of a national prepaid care plan were reported to the trustees. Mr. Bowman was authorized to represent C.P.S. at the meeting of the Council on Medical Service Plans and Public Relations of A.M.A., in Chicago on February 12th, and Dr. Gilman was authorized to represent C.P.S. at the meeting of State Presidents prior to that.

On the contract with the Veterans' Administration, it was reported that while numerous conferences have been held with the Veterans' Office in San Francisco and Los Angeles, these offices have not yet received their instructions from Washington. Until these instructions have been received, C.P.S. will authorize no care. Meanwhile, forms and procedures are being worked out to ensure smooth and simple operation of the program. As soon as

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.  
 Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

the local offices have received their instructions and the details are worked out, C.P.S. will advise all practicing physicians as to how the program will function.

C.P.S. was asked to provide hospitalization for veterans on a State-wide basis. A tentative contract has been submitted. The board approved the offer of hospitalization to veterans until the hospitals or the Blue Cross Plans are willing and able to do so. The business of C.P.S. is medical care, and C.P.S. would handle hospitalization out of necessity only, since the Veterans' Bureau will deal with just one organization on a State-wide basis.

Mr. Hassard reported that the C.M.A. Advisory Planning Committee has prepared a report to the C.M.A. Study Committee, answering certain questions raised by the latter committee. This report will remain unpublicized until after its presentation to the Study Committee.

Dr. Moore reported briefly on a recent meeting of the Study Committee.

The board approved the continuation of a \$2.00 unit for March and April.

CHESTER L. COOLEY, M.D., Secretary.

**California Physicians' Service**  
153 Kearny Street, San Francisco 8  
EXbrook 0161  
743 South Grand View, Los Angeles 5  
DRexel 5261

\* \* \*

#### V.A.—C.P.S. Fee Schedule

For convenience in future reference C.P.S. has given permission to print in CALIFORNIA AND WESTERN MEDICINE the V.A.-C.P.S. fee schedule, which follows:

(COPY)

#### VISITS AND EXAMINATIONS (001-049)

##### Maximum Charge

001	Office visits	
	First call (routine history and physical examination)	\$ 5.00
	Follow-up calls	2.50
002	Hospital visits	3.75
	Hospital visits—10 P.M. to 6 A.M.	7.50
003	Home visits	
	First visit	5.00
	Follow-up visits	3.75
	Home visits—10 P.M. to 6 A.M.	7.50
004	Visits to additional members of same household—At home	2.50
005	Consultation (in which case is returned to referring physician for treatment)	
	In the office	10.00
	At home	15.00
006	Consultation by referral (in which second physician continues with case)	
	First visit	7.50
	Follow-up calls	2.50
007	Complete history and physical examination (on authorization of Medical Director and only in cases with obscure diagnostic problems)	15.00
008	Complete neurological examination	15.00
009	Detention with patient in critical condition	
	Per hour—day time, at home or hospital.	10.00
	Per hour—after 10 P.M.	15.00
010	Mileage—per mile one way, from 3 miles beyond city limits	.50
	— to 049	

#### SPECIAL DIAGNOSTIC PROCEDURES (050-099)

050	Abdominal paracentesis	\$ 5.00
051	Allergy tests—scarification or intradermal (Costs of materials to be paid by patient)	
	20 tests	5.00
	For each additional 10	2.50
	Maximum	37.50

052	Audiogram	\$ 5.00
053	Barany test	10.00
054	Basal metabolism	5.00
055	Biophotometer tests—for Vitamin A deficiency	5.00
	Repeats	2.50
056	Blood Transfusion (not including cost of blood)	15.00
057	Electrocardiogram	7.50
058	Spinal puncture	5.00
059	Thoracentesis (diagnostic)	5.00
060	Visual fields (neurological)	5.00
	— to 099	

#### GENERAL SURGERY

(100-199)

#### Infections and Traumata (100-129)

100	*Burns	
	First degree	\$ 5.00
	Second degree	
	less than $\frac{1}{2}$ of an extremity	7.50
	more than $\frac{1}{2}$ of an extremity	15.00
	(An extremity shall be considered to be hand and arm to shoulder; foot and leg to hip; head and neck to body; body)	
	Subsequent dressings requiring more than 15 minutes, \$2.50 for each additional 15 minutes.	
	Third degree burns, requiring anesthesia depending on area involved—minimum. Larger fees for extreme destruction of tissue.	25.00
101	*Carbuncle—excision	25.00
102	*Grafts, pinch	15.00
103	*Superficial abscesses and boils—incision	5.00
104	*Other abscesses—incision and drainage	10.00
105	*Tendon of hand—drainage	25.00
106	*Traumatic wounds	

	Repair of recent small wounds, to $2\frac{1}{2}$ inches	5.00
	Repair of recent small wounds, involving subcutaneous tissue and requiring buried suture or ligature	7.50
	Repair of recent large wounds (over $2\frac{1}{2}$ inches)	10.00
	Repair of recent large wounds involving subcutaneous tissue and requiring buried suture or ligature	15.00
	Foreign body removal	
	Single superficial	3.75
	Multiple superficial	5.00
	Under skin, requiring incision to remove	6.25
	Under deep structures, requiring open operation to remove	15.00
107	*Ulcer—excision	10.00
	— to 129	

#### Cysts (130-139)

130	Aspiration	\$ 5.00
131	Branchial cyst—removal	125.00
132	Complicated cyst	25.00
133	Dermoid cyst	75.00
134	Pilonidal cyst or sinus—complete excision	75.00
135	*Sebaceous cyst—removal	

	Large	7.50
	Small	5.00
	Under skin	200.00

— to 139

#### Tumors (140-149)

140	*Complicated external—removal	\$ 25.00
141	*Epithelioma (Explain extent and procedure—fee adjusted accordingly) Minimum...	5.00
142	*Epulis—removal	15.00
143	*External papilloma (removal)—Keratosis	5.00
144	Parotoid—removal	75.00
145	Vocal cord tumor—removal	75.00
	— to 149	

#### Biopsy (150-154)

150	Bone biopsy	\$ 10.00 T
151	Superficial biopsy	5.00 T
152	Vasoscopes	25.00 T

— to 154

#### Glands (155-159)

155	*Superficial glands—removal	\$ 10.00
	— to 159	

#### Thyroid (160-165)

160	Lobectomy	\$ 125.00 T
161	Thyroid gland, simple ligation	75.00 T
162	Thyroidectomy	175.00 T

— to 164

*Breast (165-169)*

165 *Breast abscess, drainage.....	\$ 10.00
166 *Breast tumor, biopsy or enucleation of small tumor.....	25.00
167 Radical removal.....	200.00 T
(Skin grafts over 1 inch diameter, add \$27.50)	
168 Simple removal.....	100.00 T
to 169	

*Miscellaneous (170-179)*

170 Ligation, saphenous vein.....	\$ 37.50 T
171 Toe nail, ingrown—removal.....	12.50 T
172 Varicose veins, injection (medication furnished by patient).....	5.00
to 179	

*Casts (Medium Not Included) (180-189)*

When not otherwise charged for, as in dislocations and fractures.	
180 Body jacket.....	\$ 25.00
181 Extremities—hand or foot.....	5.00
182 Extremities—leg or forearm.....	10.00
183 Full upper or lower extremity.....	15.00
184 Removal of plaster cast.....	5.00
185 Removal of cast containing pins and wires used for fixation.....	10.00
186 Spica—single.....	20.00
187 Spica—double.....	25.00
to 199	

*Anesthesia and Assistants (190-199)*

190 Anesthesia, major.....	\$ 20.00
191 Anesthesia, minor.....	10.00
192 Anesthesia, whenever gas furnished by anesthetist	
Per Hour.....	20.00
193 Spinal anesthesia.....	10.00
194 Assist at major operation.....	30.00
195 Assist at minor operation.....	10.00
to 199	

**SPECIAL SURGERY  
(200-649)***Thoracic Surgery (200-219)*

200 Bronchoscopy, diagnostic, including biopsy.....	\$ 50.00 T
201 Bronchoscopy, operative.....	100.00 T
202 Empyema, rib resection.....	50.00
203 Phrenic nerve, crushing.....	25.00
204 Pleura, paracentesis.....	5.00
205 Pneumothorax, artificial—first Refills—each.....	15.00
7.50	
206 Thoracoplasty—first stage.....	200.00
Each additional stage.....	50.00
207 Thoroscopy—cutting pleural adhesions.....	62.50 T
208 Thoroscopy—diagnostic.....	37.50 T
to 219	

*Abdominal Surgery (220-289)*

220 Abdomen—paracentesis.....	\$ 5.00
221 Abdomen—peritoneoscopy.....	37.50 T
222 Appendectomy.....	125.00 T
223 Appendiceal abscess, drainage.....	75.00 T
224 Biliary drainage—duodenal tube.....	5.00
225 Cholecystectomy.....	200.00 T
226 Cholecystotomy.....	150.00 T
227 Colon, resection.....	200.00
228 Colostomy.....	125.00 T
229 Diverticulum, intestinal.....	125.00 T
230 Esophagoscopy.....	50.00 T
231 Esophagus, dilation.....	25.00 T
232 Gastrectomy.....	200.00
233 Gastro-enterostomy.....	200.00 T
234 Gastrostomy.....	50.00 T
235 Gastrotomy.....	150.00 T
236 Hernia, femoral, single.....	100.00 T
237 Hernia, femoral, bilateral.....	125.00 T
238 Hernia, reduction by taxis, single.....	10.00
239 Herniotomy, inguinal, single.....	100.00 T
240 Herniotomy, inguinal, bilateral.....	125.00 T
241 Herniotomy, umbilical.....	100.00 T
242 Intestines, anastomosis.....	150.00 T
243 Intestines, resection.....	200.00
244 Laparotomy—exploratory, for diagnosis or biopsy.....	125.00 T
245 Splenectomy.....	200.00 T
246 Ulcer, duodenal, excision.....	200.00 T
247 Ulcer, peptic, perforated, closure.....	150.00 T
to 289	

*Proctology (290-319)*

290 *Abscess, ischio-rectal, drainage.....	\$ 25.00
291 *Fisturectomy.....	25.00
292 Fistulectomy—simple.....	50.00

293 Fistulectomy—complicated horseshoe fistula.....	75.00
294 Hemorrhoidectomy—external.....	25.00
295 Hemorrhoidectomy—internal.....	100.00 T
296 Hemorrhoids, injections—each.....	5.00
297 Incision—of small abscess, thrombotic hemorrhoid, papilla, skin tags.....	10.00
298 Pectenotomy.....	50.00
299 Perirectal abscess, drainage.....	5.00
300 Polypectomy (excision or fulguration).....	50.00
301 Proctoscopy.....	5.00
302 Prolapsed rectum, repair.....	150.00
303 Rectum—radical resection or amputation for malignancy.....	200.00
304 Sigmoidoscopy—surgical.....	10.00
305 Sphincter, dilation.....	5.00
to 319	

*Urology (320-359)*

320 Bladder tumor, fulguration.....	\$ 50.00
321 Bladder irrigation.....	5.00
322 Catheterization of urethra or passing sound.....	5.00
323 Circumcision—adult.....	20.00 T
324 Circumcision—infants, 6 mo. to 1 yr.....	12.50 T
325 Circumcision—new born.....	5.00 T
326 Cystoscopy, diagnosis (bladder only).....	12.50
327 Cystoscopy, with catheterization of ureters.....	25.00
328 Cystoscopy, operative, for neoplasm.....	100.00
329 Cystotomy or cystostomy.....	50.00
330 Epididymectomy.....	50.00
331 Hydrocele, radical operation.....	50.00 T
332 Nephrectomy.....	200.00 T
333 Nephropexy.....	200.00 T
334 Nephrotomy.....	200.00 T
335 Orchidectomy.....	50.00 T
336 Orchidectomy—radical, for malignancy (explain procedure used).....	150.00
337 *Phimosis—dorsal slit.....	10.00
338 Prostatectomy—any method.....	200.00
339 Prostatic abscess.....	62.50
340 Prostatic resection—transurethral, median bar.....	100.00 T
341 Renal lavage.....	12.50
342 Tunica vaginalis, paracentesis.....	5.00
343 Ureteral stone through cystoscope.....	50.00 T
344 Ureterotomy.....	125.00 T
345 Urethroscopy.....	10.00
346 Varicocele operation.....	50.00 T
347 Vasectomy Bilateral.....	37.50 T
to 359	

*Obstetrics and Gynecology (360-419)*

360 Abortion or miscarriage (if hospitalized and cured).....	\$ 50.00
361 Atresia of vagina, correction of.....	50.00
362 *Bartholin's Gland—excision.....	25.00
363 *Bartholin's Gland—incision.....	10.00
364 Caesarian Section, abdominal. (Add 20 per cent of OBS fee if prenatal care was given)	150.00 T
365 Caesarian Section, vaginal.....	150.00 T
366 Cauterization of cervix.....	5.00
367 Cervical polyp—in hospital, with curettage	50.00 T
368 Cervix—amputation.....	75.00
369 Cervix—dilatation of.....	25.00 T
370 Cervix—repair of tear.....	37.50
371 Colporrhaphy.....	100.00
372 Conization of cervix.....	37.50 T
373 Cul-de-sac, drainage.....	50.00
374 Curettage—diagnostic or therapeutic.....	50.00 T
375 Cystocele repair.....	100.00 T
376 Fistula, recto-vaginal.....	125.00
377 Fistula, vesico-vaginal.....	125.00
378 Hysterectomy, radical, for cancer.....	200.00
379 Hysterectomy, simple, non-malignant.....	150.00 T
380 Hysterectomy, simple, non-malignant.....	150.00 T
381 Labial tumors and cysts, removal.....	27.50
382 Myomectomy, with laparotomy.....	150.00 T
383 Oophorectomy (one or two).....	150.00 T
384 Perineorrhaphy—chronic cystocele and rectocele and trachelorrhaphy.....	150.00 T
385 Perineorrhaphy—relaxed perineum.....	100.00
386 Pregnancy—prenatal care, delivery (spontaneous or forceps), supervision of child in hospital, postpartum care, including final examination.....	100.00 T
Pregnancy—delivery and postnatal care.....	75.00
Pregnancy—prenatal care only.....	25.00
387 Pregnancy—ectopic, ruptured.....	150.00
388 Rectocele repair.....	100.00 T
389 Salpingo-oophorectomy (one or two).....	150.00 T
390 Trachelorrhaphy.....	50.00 T
391 Urethral caruncle, removal.....	20.00 T
392	

393 Uterine flexions, etc., correction.....	150.00 T
394 Uterine polyp, removal.....	37.50 T
395 Vaginal plastic—including cystocele and rectocele.....	150.00 T
— to 419	

*Ophthalmology (420-459)*

420 *Canthotomy .....	\$ 7.50
421 Cataract, removal .....	150.00 T
422 *Chalazion .....	5.00
423 *Conjunctiva, suture .....	25.00
424 *Conjunctival flap for corneal ulcer, etc.....	15.00
425 *Cornea, paracentesis .....	12.50
426 *Corneal ulcer, cauterization .....	7.50
427 *Corneal ulcer, delimiting keratotomy .....	37.50
428 Entropion or ectropion, plastic operation.....	62.50
429 Entropion or ectropion, Ziegler's puncture .....	37.50
430 Enucleation of eye .....	100.00 T
431 Enucleation and implantation .....	87.50
432 Evisceration .....	62.50
433 Foreign body, interior eye, removal .....	125.00
434 *Foreign body, removal from cornea .....	5.00
435 Glaucoma, filtering operation .....	125.00
436 Iridectomy .....	62.50 T
437 *Lachrymal duct stenosis, probing .....	7.50
438 Lachrymal sac, removal .....	62.50
439 Pterygium .....	37.50 T
440 Ptosis .....	125.00
441 Refraction with mydriatic .....	12.50 T
442 Retinal detachment (multiple fusions) .....	175.00
443 Strabismus, one stage .....	75.00
444 Strabismus, two or more stages .....	100.00
445 Symblepharon, release .....	37.50
446 Tarsorrhaphy, orbicularis paralysis .....	37.50
447 *Trichiasis, electrolysis .....	17.50
448 Tumor, exenteration of orbit .....	125.00
449 Visual fields (neurological) .....	5.00
— to 459	

*Otology (460-469)*

460 Audiometer test .....	\$ 5.00
461 Mastoidectomy, acute .....	125.00
462 Mastoidectomy, bilateral .....	200.00
463 Mastoidectomy, radical .....	150.00
464 *Paracentesis tympani (myringotomy) .....	10.00
— to 469	

*Nose and Throat (470-489)*

Where it is necessary to operate on any combination of procedures the fee shall be for the major procedure plus 25 per cent of the fee for each other procedure.

470 Antrum, Caldwell-Luc .....	\$150.00
471 Antrum, Caldwell-Luc—bilateral .....	175.00
472 Antrum, puncture .....	5.00
473 Ethmo-sphenoidectomy .....	50.00
474 Eustachian Tubes—catheterization and inflation .....	5.00
475 Laryngectomy .....	200.00
476 Larynx, intubation .....	25.00 T
477 *Nasal polyp, removal .....	7.50
478 Naso-antral window .....	37.50
479 Naso-antral window—bilateral .....	50.00
480 *Peritonsillar abscess .....	10.00
481 Submucous resection .....	75.00 T
482 Tonsillectomy and adenoidectomy .....	50.00 T
483 Tracheotomy .....	50.00
484 *Turbinatectomy .....	10.00
485 Uvulectomy .....	5.00
— to 489	

*Neuro-Surgery (490-509)*

490 Chordotomy, bilateral .....	\$125.00
491 Chordotomy, unilateral .....	125.00
492 Craniotomy for tumor, abscess, depressed fracture .....	200.00
493 Decompression, subtemporal .....	125.00
494 *Encephalogram—introduction of material (x-ray extra) .....	25.00
495 Laminectomy, cord tumor or nucleus pulposus .....	200.00 T
496 Laminectomy, intervertebral disc .....	150.00
497 Lumbar puncture .....	5.00
498 Nerve anastomosis (Individual consideration) .....	125.00 down
499 Section, anterior scalenus (scalenus syndrome) .....	75.00
500 Section, 5th nerve (tri-geminal neuralgia) .....	125.00
501 Section, 8th nerve (Meniere's syndrome) .....	125.00
502 Skul defect, plastic operation .....	125.00
503 Splanchnicectomy .....	200.00

504 Trephine, subdural hematoma .....	75.00
505 *Ventriculogram—introduction of material (x-ray extra) .....	50.00
— to 509	

*BONE—JOINT—TENDON SURGERY*  
*Fractures (510-569)**Uncomplicated—Closed Reductions*

Fee includes two weeks after-care. Thereafter home, office, hospital calls allowed except where "T" is indicated.

510 Acetabulum .....	\$ 62.50 T
511 Carpal .....	25.00
512 Clavicle .....	50.00 T
513 Colles' Fracture .....	62.50
514 Femur .....	100.00
515 Forearm—one bone .....	37.50 T
516 Forearm—both bones .....	62.50
517 Humerus .....	50.00 T
518 Ilium .....	62.50 T
519 Leg—one bone .....	50.00 T
520 Leg—both bones .....	75.00
521 Mandible .....	37.50 T
522 Maxilla .....	20.00 T
523 Metacarpals .....	25.00
524 Metatarsal .....	25.00
525 Nasal Bones .....	25.00
526 Olecranon .....	37.50 T
527 Os Calcis .....	25.00 T
528 Patella .....	50.00 T
529 Pelvic .....	62.50 T
530 *Phalanx of finger .....	5.00
531 Phalanx of toe .....	10.00
532 *Phalanx—each additional .....	5.00
533 Pott's Fracture .....	75.00
534 *Ribs .....	10.00
535 *Ribs—two or more .....	20.00
536 Sacrum .....	62.50 T
537 Scapula .....	50.00 T
538 *Skull .....	25.00
539 Sternum .....	20.00
540 Tarsal .....	25.00

If Fracture is comminuted or compound or multiple or involves a joint, enough to interfere with reduction and control, add 50 per cent to fee for simple fracture.

Open reduction with internal fixation, for bone plating or bone splinting or inlay, two times fee for simple fracture.

Skeletal traction, including use of tongs, wires, pins, add 50 per cent to fee for closed reduction.

For bone graft of ununited fracture, three times the fee for treating the original fracture.

For bone drilling for delayed union or ununited fracture, same fee as for treating original fracture.

Open operation for removing splinters of bone from open wound, simple sequestrum, plate, screws, or internal splint material: charge fee for simple fracture.

Reduction of vicious union by use of Thomas wrench, add 50 per cent for simple fracture.

— to 569

*Dislocations (570-579)*

570 *Dislocations—easy reductions without anesthetic or assistance .....	\$ 10.00
571 *Dislocations—major reductions under anesthesia .....	25.00
— to 579	

*Joint Surgery (580-594)*

580 Acromio-clavicular separation—repair of .....	\$150.00
581 Arthrodesis—shoulder, elbow, sacro-iliac, hip or knee .....	200.00
582 Arthrodesis—wrist, ankle, foot .....	100.00
583 Arthroplasty—shoulder, elbow, hip or knee .....	200.00
584 Arthroscopy—large (shoulder, knee) .....	75.00
585 Arthroscopy—small (ankle, wrist) .....	50.00
586 *Aspiration—small joints (ankle, wrist) .....	5.00
587 *Aspiration—large joints (shoulder, knee) .....	12.50
588 Cartilage, semi-lunar—removal of detached .....	100.00 T
589 Disarticulation at hip or shoulder joint .....	150.00
590 Ligaments, knee—repair of crucial .....	150.00
591 Ligaments, knee—repair of lateral .....	100.00
592 *Manipulation of joints or back—under anesthesia .....	25.00
593 *Manipulation of joints or back—simple .....	5.00
594 Patella—repair of recurrent dislocation .....	100.00

<i>Other Orthopedic Procedures (595-649)</i>	
595 Albee or fixation operation.....	\$200.00
596 *Amputations—finger or toe.....	15.00
597 *Amputations—finger or toe—each additional.....	5.00
598 Amputations—foot, ankle or leg.....	75.00
599 Amputations—hand, wrist, forearm, arm.....	75.00
600 Amputations—knee or thigh.....	100.00
601 Amputations—hip.....	150.00
602 Astralectomy.....	100.00
603 Bunion operation, plastic—one foot.....	62.50
604 Bunion operation, plastic—both feet.....	100.00
605 Boehler Method (os calcis fracture with cast).....	125.00
606 Bursa—excision of, large.....	50.00
607 Bursa—excision of, small.....	30.00
608 Bursa—injection of novocaine.....	12.50
609 Bursa—repair of wounds or removal of foreign bodies—50 per cent of fee for excision.....	
610 Fasciotomy—Ober's.....	75.00
611 Ganglion—removal of.....	37.50
612 Laminectomy.....	200.00 T
613 *Lavage—of shoulder joint for calcified bursa.....	25.00
614 *Osteomyelitis, acute—small incision for drainage.....	25.00
615 *Osteomyelitis, acute—large incision for drainage.....	50.00
616 *Osteomyelitis—sequestrectomy—small.....	50.00
617 *Osteomyelitis—sequestrectomy—large.....	75.00
618 Removal of metatarsal heads.....	25.00
619 Removal of carpal bones.....	37.50
620 Removal of spinous process.....	37.50
621 Removal of spurs and exostoses.....	37.50
622 Smith-Peterson operation (sacro-iliac).....	200.00
623 *Tendon surgery—lengthening.....	62.50
624 *Tendon surgery—sutures, each tendon (not to exceed \$200.00 T).....	37.50
625 *Tendon surgery—tenotomy (subcutaneous) (two or more, add 50 per cent).....	30.00
626 *Tendon surgery—transplants.....	75.00
Transplants—each additional (not to exceed \$150.00).....	37.50
627 Traction skeletal, when not part of fracture fee otherwise charged.....	12.50
— to 649	
<i>PATHOLOGY (650-799)</i>	
<i>Tissue (690-659)</i>	
650 Surgical pathological diagnosis.....	\$ 10.00
651 Frozen section.....	25.00
— to 659	
<i>Sputum (660-669)</i>	
660 Smear for tubercle bacilli.....	\$ 2.50
661 Concentration method for tubercle bacilli.....	5.00
662 Pneumococcus typing.....	5.00
— to 669	
<i>Stomach Contents (670-679)</i>	
670 Fractional tests (meal, alcohol and/or histamine).....	\$ 10.00
671 Gastric Analysis.....	5.00
— to 679	
<i>Feces (680-689)</i>	
680 Microscopic examination (parasites and ova).....	\$ 5.00
681 Occult Blood.....	.50
— to 689	
<i>Spinal Fluid (690-699)</i>	
690 Diagnostic spinal fluid (includes cell count, globulin flocculation).....	\$ 10.00
691 Diagnostic spinal fluid—plus colloidal gold (additional).....	2.50
692 Diagnostic spinal fluid—plus glucose (additional).....	2.50
693 Extra tests (see Blood).....	
— to 699	
<i>Bacteriological Examinations (700-709)</i>	
700 Direct smears (gonorrhea, trichomonas, etc.).....	\$ 2.50
701 Culture—simple.....	2.50
702 Animal inoculation.....	5.00
703 Guinea pig inoculations for tuberculosis—one pig.....	7.50
704 Guinea pig inoculations for tuberculosis—two pigs.....	10.00
— to 709	
<i>Urines (710-729)</i>	
710 Routine chemical and microscopic.....	\$ 1.50
<i>Blood (730-789)</i>	
711 Quantitative—sugar or albumen (only).....	.50
712 Phenolsulphophthalein (charge patient for dye).....	
Bladder urine—2 samples.....	2.50
713 Phenolsulphophthalein—cystoscopic, both ureters.....	3.75
— to 729	
<i>Blood (730-789)</i>	
730 Agglutination tests—3 antigens, Widal, etc. \$ Each additional antigen.....	5.00 1.25
731 Blood Culture (of recognized diagnostic value).....	5.00
732 Blood Typing and Matching.....	2.50
(\$2.50 for each of first two tests. Subsequent tests after first two done during consecutive period of observation of illness).....	
(Patient and more than three donors in search for compatible blood) Maximum.....	10.00
733 Calcium.....	5.00
734 Chloride.....	5.00
735 Cholesterol.....	5.00
736 Coagulation and bleeding time.....	1.50
737 Complete blood count—hemoglobin, red blood count, white blood count, differential.....	5.00
Complete blood count—requiring call to home.....	10.00
738 $\text{CO}_2$ determination.....	7.50
739 Creatinine.....	5.00
740 Fragility of corpuscles.....	5.00
741 Glucose.....	5.00
742 Glucose tolerance (1 hour, 2 dose test, or 1 and 2 hour methods) 5 samples.....	10.00
743 Hemoglobin—chemical.....	1.25
Hemoglobin—Talquist.....	.50
744 Heterophile antibody.....	5.00
745 Icterus index.....	2.50
746 Liver function tests.....	7.50
N. P. N.....	5.00
747 Phosphatase.....	5.00
748 Phosphorus.....	5.00
749 Platelet count.....	2.50
750 Red count and hemoglobin.....	2.50
751 Reticulocyte or platelet count (to be added on to other charges for blood examination).....	1.25
752 Sedimentation rate (graph).....	5.00
753 Sedimentation time.....	2.50
754 Smears for parasites (malaria, etc.).....	1.50
Sugar—quantitative in blood.....	5.00
755 Sulpha drugs—blood level.....	5.00
756 Urea.....	5.00
757 Urea clearance.....	7.50
758 Uriac Acid.....	5.00
759 Vandenberg (quantitative or qualitative).....	2.50
760 Wassermann, Kahn, Kline or Hinton (selection of one—checks not allowed extra).....	3.00
761 White count and differential.....	2.50
762 White count and differential and hemoglobin.....	3.75
— to 789	
<i>Miscellaneous (790-799)</i>	
790 A. Z. test.....	\$ 5.00
791 Friedman.....	7.50
792 Basal Metabolic Rate.....	5.00
793 Dark field, for <i>Treponema Pallida</i> .....	5.00
794 Electrocardiogram, with interpretation and report.....	7.50
— to 799	
<i>RADIOLOGY (800-889)</i>	
800 Abdomen—for pregnancy.....	\$ 10.00
801 Abdomen—plain examination.....	10.00
802 Additional procedures (such as stereoscopic oblique projections of lumbar articulations) in conjunction with routine examination.....	33% additional
Barium enema.....	15.00
Barium enema and gastro-intestinal series.....	35.00
Bladder or cystogram.....	10.00
Bronchography (including opaque oil and injection).....	20.00
Cervical spine.....	15.00
Check-up examinations of fractures (within 24 hours).....	At one-half original charge
Chest plate.....	10.00
Cholecystography (including dye).....	15.00

811	Cholecystography— and gastro-intestinal series .....	35.00
812	Consultation on examinations made at outside offices .....	10.00
813	Encephalography .....	25.00
814	Entire spine, complete studies .....	35.00
815	Eye, for foreign body .....	10.00
816	Eye—foreign body localization .....	20.00
817	Finger, fingers, toe or toes .....	5.00
818	Fluoroscopic examination .....	5.00
819	Fluoroscopic examination — in conjunction with procedures such as myelography, requiring unusual time .....	10.00
820	Foot, heel or ankle .....	7.50
821	Full denture .....	10.00
822	Gall bladder (plain examination) .....	10.00
823	Gastro-intestinal series, complete, including barium enema and cholecystography .....	45.00
824	Gastro-intestinal series, with barium enema OR cholecystography .....	35.00
825	Gastro-intestinal series, without barium enema or cholecystography .....	25.00
826	Hand, wrist or elbow .....	7.50
827	Kidneys or plain KUB .....	10.00
828	Knee, hip or femur .....	10.00
829	Lumbar spine .....	12.50
830	Lumbosacral spine .....	15.00
831	Lungs and heart, including fluoroscopy .....	15.00
832	Mastoids .....	12.50
833	Nasal bones .....	10.00
834	Oesophagus .....	15.00
835	Partial denture .....	5.00
836	Pelvimetry .....	20.00
837	Portable examinations at patient's home (additional fee) .....	15.00
838	Pyleogram (intravenous, including dye and administration) .....	25.00
839	Pyleogram (retrograde) .....	15.00
840	Ribs or sternum .....	12.50
841	Salpingography .....	20.00
842	Shoulder, scapula or clavicle .....	10.00
843	Sinuses .....	12.50
844	Skull—complete examination .....	20.00
845	Skull—for sella turcica or bones of face .....	12.50
846	Thoracic .....	12.50
847	Tooth .....	1.25
	— to 849	

#### Radiological Therapy (850-888)

##### (Per Treatment Visit)

850	Adenitis .....	\$ 5.00
851	Cancer—superficial (depending on size, location and technical difficulties) .....	10.00-100.00
852	Hemorrhagic conditions—prolonged coagulation time, etc. ....	5.00
853	Infections and Inflammations—carbuncles, furuncles, paronychia, etc. ....	5.00
854	Keratosis .....	5.00
855	Skin conditions—Acne dermatitis, erysipelas, wart, etc. ....	5.00
	Minor or intermediate roentgen treatments may need repetition, especially minor ones, as much as five times. If more than six such minor treatments are considered necessary in any one case, special authorization shall be obtained.	
856	Cancer of breast, prostate, testis, bladder, uterus (complete course, 3 to 6 weeks' treatment, treatments being given daily or close together) .....	200.00 T
857	Pre and postoperative (complete course) in conjunction with surgery .....	159.00 T
858	Preoperative irradiation (short intensive course) .....	50.00 T
859	Hyperthyroidism (complete course) .....	100.00 T
860	Menorrhagia, fibromyoma uteri .....	100.00 T
861	Single treatment .....	10.00
	— to 888	

Includes preliminary clinical examination, consultation, current visits and use of equipment or cost of providing radium. By full course of roentgen or radium irradiation is meant approximately three to six weeks of roentgen treatment, the treatments being given daily or close together, however large a number of fields is used. The fee shall include preliminary clinical examinations, consultation and all current visits.

Unclassified radium entities where authorization for global fee has not been obtained

and where part of medical fee has or has not already been paid—(or above)—1.5 cents per milligram hour, plus insertion charge \$12.50 to \$25.00 (depending on difficulties of the medico-surgical procedure).

#### 889 Services not otherwise classified

##### GENERAL INSTRUCTIONS

- Fee includes surgical procedure and two weeks after care except where "T" is indicated. Where "T" is indicated, the fee is total.
- Starred items (\*) indicate fee for surgical procedure itself, after care additional.
- Assistants bill C.P.S. separately.
- Anesthetists bill C.P.S. separately.
- Medical follow-up during surgery and postoperative care by a second physician is not allowed, except in cases where complications develop and attending surgeon requests consultation. In such instances authorization from Medical Director must be obtained. Emergency operations at night, 10 p.m. to 6 a.m., add 50 per cent to minimum fee.
- Unusual cases and those not specifically listed are entitled to the same fee as a listed procedure of closest similarity.

#### Home Town Medical Care for Veterans

The sensible and economical home medical service guaranteed to California veterans through agreement between the Veterans' Administration and California Physicians' Service adds to the debt of gratitude the American people owe Veterans' Administrator General Omar N. Bradley.

He is an administrative genius who knows what he wants for the veterans—and gets it. He forced long-needed service reforms in veterans' hospitals. He put an end to political log-rolling in the building locating of hospitals. And the problem he has licked with the co-operation of California doctors was a knotty one. This State already has 1,300,000 ex-service men and women. Of World War II veterans, nearly 70 per cent claim service-connected disabilities. The great majority are not ill or incapacitated enough to require separation from their homes and jobs in veterans' hospitals, but do need the best in medical service as out-patients, and are entitled to it without delay, red tape or personal cost.

The problem has been solved simply and permanently. After February 1, any veteran determined eligible by the Administration for out-patient care at Government expense may go to any C.P.S. doctor for treatment. The doctor will be paid on the basis of a fee schedule set up in the contract between C.P.S. and the Administration.

There are C.P.S. medical men in every community. It is due to the progressiveness of the California Medical Association, which pioneered the field of voluntary pre-paid medical care by organizing and financing California Physicians' Service, that the type and standard of health service sought by General Bradley was in readiness in the State.

Undoubtedly the California program will be a pattern for national emulation. Every veteran whose physical well-being was impaired in the service of this country is certainly entitled to the finest of medical care. And California is indeed fortunate that this service can be provided on a home-town basis, without government regimentation of either the veteran or the medical profession. —Lower Lake *Observer*, January 17.

#### Veterans Assured Medical Care in California

California veterans, under the terms of a contract just completed in Washington between General Omar N. Bradley, veterans' administrator, and California Physicians' Service, today were assured of prompt, home-town medical care at government expense for service-connected disabilities which do not require hospitalization.

with the right to choose their own doctors from the 6,000 professional members of C.P.S.

The far-reaching veterans medical care program, designed to eliminate delays and red tape by enabling service men who need treatment, but not hospitalization, to be cared for in their own communities, will be available to California service men of World War I and the Spanish-American War, as well as those of World War II.

California has approximately 1,310,000 veterans of the three wars, it was announced, and nearly 70 per cent of currently discharged veterans are claiming service-connected disabilities. The new plan becomes operative on February 1, 1946, and will be put in operation within a few weeks thereafter, as fast as arrangements can be made.

William Bowman, executive director of California Physicians' Service, in announcing the program, quoted General Bradley and Major General Paul R. Hawley, acting surgeon general of the veterans' administration, as declaring:

"We are very pleased to make this contract with California Physicians' Service because it assures California veterans of high quality medical care in their own home communities."

The Veterans' Administration, Mr. Bowman announced, will screen veteran applicants to determine those eligible for out-patient care at government expense and will certify them to C.P.S. The veteran can then go to any C.P.S. doctor for treatment; the doctor will send his bill to C.P.S. which, in turn, will bill the government. The doctors will be paid on the basis of a fee schedule set up in the contract between the Veterans' Administration and C.P.S.

California Physicians' Service, a voluntary health insurance system founded eight years ago by the California Medical Association, embraces in its professional membership the great majority of California doctors, both general practitioners and specialists, and its membership extends into every community in the State.—Richmond *Record-Herald*, January 10.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

### "Jobless Pay For the Sick" Bill Passed By California Legislature

Final legislative approval was given by the Senate on February 14 to the establishment of a State system of unemployment disability payments.

An abortive last-hour attempt was made to torpedo the Shelley bill, setting up the machinery for the disability payments to an estimated 2,600,000 workers under unemployment compensation insurance.

The move involved charges that industry and business representatives were attempting to renege on amendments written into the measure, and countercharges that labor representatives had sneaked in Assembly changes in the original bill. But the final roll call showed the Senate voting, 26 to 10, to concur in the amendments.

The bill now goes to Governor Warren for his signature. Warren urged the Legislature to enact the measure. Senator Shelley, principal proponent of the act, has been working on the program for more than six years. During the past four years a Senate interim committee has also worked on the measure. Shelley was chairman of the committee and the members of the group were co-authors of the bill given final approval.

The purposes of the Shelley bill are to compensate in

part for the wage loss sustained by workers unemployed because of sickness and injury and to reduce suffering caused by unemployment resulting therefrom.

Under the measure a worker, if eligible, will be entitled to both unemployment compensation disability benefits and unemployment compensation benefits in the same year.

### Disability Insurance

It is quite appropriate that the State Senate should scrutinize closely provisions of Senator Jack Shelley's disability insurance bill (a Warren Administration measure) but justice forbids that the measure should be killed by amendments, rather than by a straight-away vote upon its merits.

Action upon it has been held up in the Senate by introduction of amendments. One of these, introduced by Senator Ward of Santa Barbara, would prohibit payment during any one year of both sickness and unemployment benefits to the same person. This would almost completely defeat the purpose of the legislation.

Obviously a worker may be unemployed at one time and ill at another and thereby suffer serious personal loss in each case. Or unemployment and illness might occur simultaneously which would be even a more disastrous experience. Unemployment insurance is intended to tide a worker over the period of no income. Disability insurance is to help him pay the cost of getting well. They are entirely distinct in purpose and should not be confused in legislation.

True, the bill proposes to pay disability benefits out of unemployment insurance fund. But that is perfectly logical inasmuch as workers have contributed almost 300 million dollars to the fund by their payroll deductions. It is to their interest and that of the employers to receive proper medical care in order to keep them fit for productive work and their earning power unimpaired. Proper attention during illness, which the bill guarantees, would be an aid to that end.

California and three other states require worker contributions to the unemployment insurance fund. One of the others, Rhode Island, sets aside the entire worker contribution for disability insurance.

Our state's unemployment insurance fund now totals 733 million dollars, of which, as we pointed out, the workers have contributed approximately 300 million dollars. Department of employment statisticians estimate that even under extreme depression conditions, with widespread joblessness, the employers' share would be more than adequate to pay unemployment benefits. They also figure disability payments would, under extreme conditions, not exceed 35 million dollars a year, whereas worker payments into the fund average about 47 million dollars.

This money comes out of the workers' pay envelopes. The employer can pass his share on to his customers in increased prices. It is only a matter of simple justice to grant that the workers are entitled to extra benefits from their share of the fund. This is particularly true in California and the three states that tax the workers for the fund. In all the other states the workers, who pay nothing, receive the same benefits now allowed workers in this State. Surely California workers are due more protection because they share the burden.—San Francisco *News*, January 30.

### Michigan Doctors Concerned Over Trend Toward Socialized Medicine

The continued drift of the nation toward state socialism, although to a lesser degree than in the case of England under the Attlee labor government, is illustrated

by President Truman's message to Congress (Nov. 19) advocating national compulsory health insurance.

It is not the presumptuous intention of this column to proclaim judgment on the merits of national health insurance. We do feel, however, it is proper and timely to present the viewpoint of the average Michigan physician and surgeon, as represented by his state professional organization, and to outline briefly the general issue involved.

Medical care is a subject that reaches into the intimate lives of every man, woman and child in every community of Michigan.

Health insurance typifies the growing controversy over voluntary vs. compulsory action as a solution of our many complex problems.

*Prior to World War II*, compulsory health insurance had been adopted by twenty-nine countries with a combined population of more than 500,000,000.

Five additional nations, as a substitute for compulsory health insurance, granted government subsidies to volunteer organizations (sponsored by doctors) which insured their members in an acceptable manner. They are: New Zealand, Belgium, Sweden, Denmark and Spain.

The American movement began about 1915 following the adoption in England of the British Insurance Act of 1911. However, the idea was not received favorably at the time. The American Medical Association went on record against it in 1920; among the critics were insurance companies, many employers' organizations, druggists and patent-medicine manufacturers, the American Federation of Labor through President Gompers and the executive council, and several religious groups. It was denounced as being un-American, socialistic, a wrong method of attack, and a death blow to the personal relationship between doctor and patient—just to mention a few objections.

*After considerable discussion, the Michigan medical profession chose to do something about it.*

The Michigan State Medical Society, 4,800 members strong, evidenced its progressive leadership by recognizing the basic need for prepaid health insurance.

Instead of compulsory insurance under government control, the Michigan remedy was this: Two volunteer non-profit corporations, the Michigan Medical Service and the Michigan Hospital Service, each chartered by the state legislature in 1939 whereby any citizen is eligible to subscribe to low-cost insurance covering both medical and hospital expenses.

Today the Hospital Service has more than 1,000,000 members; the Medical Service, close to 900,000. No other state health insurance program has begun to approach this outstanding success. Michigan not only leads the entire country; it leads the world.

*Paradoxically, Michigan's progress reveals and emphasizes a weakness of the American medical profession.*

While 868,000 persons are now insured in Michigan against medical expense incurred during ill health, only 200,000 are so protected in Massachusetts and 175,000 in California, second and third ranking states in voluntary health insurance.

To dispel the apathy prevailing elsewhere, the Michigan medical society last April invited presidents of 17 state groups in the Middle-West to a conference in Detroit. Its success led to the calling of a western regional conference in Colorado last June for ten states.

And finally, in an effort to induce national action, the co-operating 27 states—led by Michigan—sponsored a national conference in Chicago held on December 2, 1945.

While Michigan leaders remain discreetly silent, doctors admit privately that Michigan's leadership has not received the blessing and support of the august and distinguished American Medical Association which remains officially aloof, now as in the past, from the field of social insurance.

*The dilemma of Michigan doctors is clear.*

No matter how perfect Michigan's insurance program may become, Michigan alone cannot stem the spreading tide of socialized medicine.

Unless all state medical societies co-operate for positive local action, some degree of national health insurance appears now to be inevitable within a decade. Our economic loss due to illness is tremendous. Quoting President Truman: "On the average day there are about 7,000,000 persons so disabled by sickness or injury that they cannot go about their usual tasks."

The number of days lost by illness is forty times greater than the time involved in industrial strikes over a ten-year period.

Forty per cent of counties in the United States lack a hospital; this deficiency is particularly severe in rural areas.

*You can't blame the Michigan doctors for being genuinely concerned.*

If voluntary medical insurance can meet the challenge, national insurance and control may be averted. Can the "forest fire" be stopped? Is there time?

It is another test of the free enterprise system; of the voluntary co-operation vs. state collectivism.

History insists that every great war is followed by drastic change. A sharp swing to the left, bringing socialization of our modern economic life, would inundate the institution of private medicine just as it would everything else. The doctor's dilemma affects us all.—By Gene Alleman, Michigan Press Association.

**Proposed Federal Bill, H.R. 5296—Re Income Tax Deductions for Free and Charity Services Rendered**

(COPY)

Congress of the United States

House of Representatives

Washington, D.C., February 15, 1946.

Dear Sir:

You will agree with me, I am sure, that the rising cost of living has affected the physicians, surgeons and dentists perhaps more adversely than any other key group in American life.

It is my thought that the economic burden upon the members of these professions might be appreciably eased, if appropriate recognition were made of the tremendous volume of non-remunerative work carried on by the physicians, surgeons and dentists of the United States—such recognition to be made, in a very practical way, by the Commissioner of Internal Revenue.

Accordingly, I have introduced a Bill (H. R. 5296) in the House of Representatives specifically allowing physicians, surgeons and dentists to enter as a deduction in their income tax, a credit equal in terms of percentages to the amount of time they devote each year to charity, free clinical work and public research work. A copy of the Bill is attached for your immediate reference.

It is my hope that this Bill will meet with the approval of your membership, and further, that you will take action to help bring the matter to the favorable consideration of the Congress. In this connection, it would appear essential that the Ways and Means Com-

mittee of the House be made aware of the widespread public interest in this urgent question. It is, therefore, my hope that you will find it possible to write to the members of that Committee—their names are given on the list attached—urging that hearings be set at the earliest possible moment. Naturally, such action on your part will be most effective if you will write to those members of the Committee representing the area nearest your residence.

In order that I may be kept aware of your activities, and follow through appropriately from the Washington end, may I suggest that you send me copies of your letters?

I shall be most interested in hearing further from you.

Sincerely yours,

(Signed) CLAIRE BOOTHE LUCE,  
(Member Congress, 4th District Connecticut)

California members of the Ways and Means Committee of the House:

(Address: c/o House Rep. Office Building, Washington, D. C.)

Cecil R. King, of Los Angeles, California.

Bertrand W. Gearhart, of Fresno, California.

1 1 1  
79th Congress, 2d Session

H. R. 5296

*In the House of Representatives*

January 30, 1946

Mrs. Luce introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To amend the Internal Revenue Code, as amended, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 23-q of the Internal Revenue Code is amended by adding the following new paragraph, to read as follows:*

"(4) That commencing with the taxable year 1946, physicians, surgeons, and dentists shall be allowed an additional credit as a deduction on their income tax equal in terms of percentages to that portion of their time each year which is devoted to charity, free clinic work, and/or public research work;

"(5) The Commissioner of Internal Revenue shall prescribe by regulation the method of computing such time and the proof which shall be required in substantiation thereof."

**Association of American Physicians and Surgeons (AAPS) Writes President Truman—Dr. Parran, Surgeon General, Replies—AAPS Answers the Surgeon General**

Complying with a directive from the A.A.P.S. House of Delegates, Dr. Harold T. Low, president of A.A.P.S., strongly objected to President Truman's compulsory insurance plan in a letter addressed to the President on November 28, 1945. The A.A.P.S. president informed Mr. Truman that members of A.A.P.S. would not participate in any such scheme and gave the Association's reasons for such refusal.

Dr. Thomas J. Parran, Surgeon General of the United States, replied for the President on December 26, 1945. The Surgeon General's response suggested an implied threat against the Association because of its stand of non-participation. . . .

The Association answered Dr. Parran's letter on January 10, 1946. . . .

Copies of the three letters follow in date sequence.

All physicians are urged to read them carefully—particularly Dr. Parran's reply. They give an indication of what the American medical profession can expect if the profession and the unsuspecting public are ever dosed with compulsory health insurance and resulting socialization of medicine. . . .

*Association of "American Physicians and Surgeons"  
Response to Dr. Parran's Letter*

January 10, 1946.

Doctor Thomas J. Parran,  
Surgeon General of the United States  
Public Health Service,  
Washington 14, D.C.

Dear Doctor Parran:

We have received your letter of December 11, which is in reply to our letter of November 28 addressed to President Truman.

Our American form of government is indeed, as you point out, a representative form of government in which it is intended that the will of the people shall be expressed through the acts of the Congress, and this Association believes in and is loyal to that system of government.

In our letter to the President, we informed him that members of this Association would not service any compulsory health insurance program because it would inevitably lead to deterioration of medical care. In reply you state: "It is therefore an alarming symptom that any responsible group—especially a professional group—should take a position of non-coöperation, even of boycott, of a proposed law if such law be enacted." Further, you say: "The President has asked me to say that an overwhelming majority of the people would condemn your Association's policy of non-coöperation; and that he does not believe that any appreciable number of physicians and surgeons would join in your program—certainly not if they understood the significance of what they would be doing."

If these quotations from your letter correctly reflect the view of the President, may we ask if he has had a change of heart, for, in a public statement on November 19, the President is quoted as saying physicians would remain free to accept or reject patients and decide whether to participate in the system (compulsory health insurance) full time, part time, or *not at all*.

May we ask what is implied in the warning by the President that physicians would not join in our program "if they understood the significance of what they would be doing." Are we to infer that there is, after all, behind this bill a program or purpose of forcing physicians into the plan? If there is, this is the time for the physicians, and their patients as well, to know what it is and how it is proposed to carry it out. We construe your language to be a veiled threat against those who choose to remain out and the forerunner of coercive measures not yet revealed. We have the right to immediate full disclosure on this point.

We presume the President means what he said on November 19. Therefore, why is it "an alarming symptom"?—why is it "non-coöperation"?—and why should we be "condemned"? The members of this Association merely decline to participate in schemes of compulsory health insurance, which the President has publicly declared is their right.

You speak of "boycott—on the people of the United States." The Association of American Physicians and Surgeons proposes no present or future boycott against the people—our patients. Were compulsory health insurance legislation to be enacted we would care for our patients just as we always have, and we would let them know that our services are rendered as free men and not

as serfs of the State. As to our rights as physicians to remain out of the scheme, we do not construe the President's declaration of November 19th to this effect as a concession or grant to us, but merely as the recognition by him of an inherent right, guaranteed by the Constitution of the United States, which we possess. Members of the Association will never "strike" against our present rightful employer, the people—our patients, but we are serving unequivocal notice of a permanent and unalterable "strike" against an improper potential employer—the State.

Our aim is to preserve the most efficient progressive and finest system of medical practice in the world against the tragic threat that is carried in your proposal.

In your letter you dismiss the possibility of deterioration of medical care (under a scheme of compulsory health insurance) with a bland statement that you do not believe the danger "is supported by experience."

We are confident that you, as a physician, will concur with the quite prevalent belief that up to now the "free" medical care dispensed by the Veterans' Administration is one of the most glaring examples of the failure of federalized or socialized medicine. Also, as a physician, you should know that compulsory health insurance, providing for the government to fix and pay physicians' fees, is socialization of medicine. A comparison of health records of this country with those countries which have schemes of government control of medicine, strongly supports our statement, "Any compulsory health insurance program would inevitably impair the quality of medical care received by the people."

Voluntary health plans are expanding, as rapidly as is commensurate with healthful growth, in 22 of the states, with many more states in the process of reorganizing plans suited to their individual needs. The people have to be educated in many cases to the value and need of insurance against the expenses of serious illness, actuarial standards to determine the cost of various types of coverage have to be developed, high standards must be maintained, and certain abuses have to be eliminated. All of this represents orderly evolutionary change in a desirable direction, which we feel is vastly to be preferred to the revolutionary disorderly change which you propose. Rome was not built in a day. Look at the record of American Medicine and consider whether you wish to jeopardize this record by advocating the sort of socialistic and Utopian change which some less fortunate nations than ours (i.e., Germany, England, Australia) have adopted only to have serious and extreme disintegration of the quality of care received by the people of these nations follow in the wake of such change.

Under the circumstances, every physician is under, the most urgent moral obligation to oppose what you are asking the Congress to do, and by every means at his command; and his obligation would be in no way lessened if such proposals were enacted into law. To a physician, as a physician, the welfare of his patient is the highest law and paramount to everything. When this is no longer possible, he stops being a physician. Remember the President said that physicians may exercise their judgments as to whether they should work under the proposed law, and we intend to consider the welfare of the patient as of the highest importance in making up our minds on the subject.

The President has said that the people of the United States will have a health insurance program just as they have fire insurance. The utter lack of analogy is too clear for argument. People take fire insurance if they want it, and not because somebody forces it upon them. Moreover, they pay a premium which is comparable to and based upon the risk involved—not upon their income and earnings. Under the plan outlined in Senator

Wagner's pending bills, there is no relation whatever between the amount assessed against an insurance individual and the risk of covering him. This violates every principle of insurance of whatever kind or nature. The essence of the fallacy in this scheme is that men do not pay in proportion to their probable benefits or risk of coverage, but an arbitrary sum (taxes) designed to pay for something that somebody else gets.

When you can propose any plan for the improved distribution of medical care that will, at the same time, retain or enhance the quality of the care, you will find every physician in the country solidly supporting you.

However, no compromise is possible with the basic fundamental principle of individual initiative and reward for competency, skill and industry, so that we cannot do other than to remain unalterably opposed to any form of compulsion in this sphere, because any such scheme is incompatible with our fundamental beliefs as Americans and our fundamental rights and duties toward our fellow man, as citizens generally and as physicians specifically.

Very truly yours,

ASSOCIATION OF AMERICAN  
PHYSICIANS AND SURGEONS,  
HAROLD T. LOW, M.D.,  
President.

## COMMITTEE ON POSTGRADUATE ACTIVITIES

### Obstetrical and Gynecological Assembly of Southern California

Applied psychiatry has become a matter of primary concern in the treatment of gynecological and obstetrical patients.

That thesis was expounded on February 19 to 100 physicians and surgeons meeting at the Elks Club in the Obstetrical and Gynecological Postgraduate Assembly of Southern California.

The speaker was Dr. Paul A. Griebe, who pioneered adult sex education at the University of California's School of Medicine at San Francisco.

While most of his discourse, the second of ten lectures he will give before the week-long conference, was highly technical, Dr. Dr. Griebe gave an interview immediately after the morning session to describe his theories in lay terms.

#### Problems Provoked

"We have learned in psychosomatic medicine," he said, "that emotional problems provoke tensions in human beings, leading to well-recognized physical complaints and disorders."

"How to meet these problems is becoming more and more a topic of sober discussion in medical-surgical circles."

Whole clinics, Dr. Griebe said, are now devoted to the study and cure of "emotional ailments." Among these is U.C.'s Langley-Porter Clinic in San Francisco.

"Conversely," he went on, "we are making every effort to discover the physiological factors that operate in producing psychological disorders. How can we 'cure' these emotional complaints—which frequently develop to such a degree that they are actually diagnosed as asthma, epilepsy, ulcers, heart disease, or even hay fever?"

"We must educate adolescents before they acquire harmful psychoses."

#### Parental Factor Stressed

"And," Dr. Griebe said flatly, "we must educate parents

themselves. Mothers and fathers can implant ideas and fixations in their children that will, in later years, break forth as genuine emotional ailments."

Dr. Griebe characterized the current increase in divorces as a "wave of domestic unrest." But he said that the war did not bring it about. Rather, he explained, the war is being used as an "excuse by the 75 per cent of the married couples who would have separated anyhow." He feels that this situation will "level off."

Doctors attending the conference, which probably will become an annual "postgraduate course" to disseminate America's latest obstetrical and gynecological knowledge to Southwesterners, viewed an elaborate display of post-war medical and surgical equipment, much of which is manufactured locally.—*Los Angeles Times*, February 20.

#### Los Angeles Health Group Conference—Disease Prevention Week

Educators, health workers and physicians in Los Angeles, attended a Biltmore civic luncheon in one of the main observances of Disease Prevention Week. Dr. Walter H. Brown, dean of the University of California School of Public Health, Berkeley, spoke.

Dr. Ruth J. Temple, Community Health Association medical director, announced that the "War on Disease" show at the County Museum in Exposition Park will continue each afternoon for an indefinite period.

Thousands of persons already have visited the show to study exhibits dealing with diphtheria, whooping cough, smallpox, tuberculosis and social diseases.

#### Annual Stanford Lecture Course—64th Series

The Stanford University School of Medicine announces the Sixty-Fourth Course of Popular Medical Lectures (illustrated) for the year 1946.

Lectures will be given at Lane Hall, on north side of Sacramento Street, near Webster, on Friday evenings. Dates and hours: March 1, March 15, March 29, and April 12, 1946 at eight o'clock sharp.

All interested are cordially invited to attend.

#### Program

Friday Evening, March 1, 1946

"*Poliomyelitis*," How It Starts: Harold K. Faber, M.D.  
Its Early Treatment: William H. Northway, M.D.  
Its Late Treatment: Donald E. King, M.D.

Friday Evening, March 15, 1946

"*Surgery of the Heart*," Emile F. Holman, M.D.

Friday Evening, March 29, 1946

"*The Conquest of Communicable Disease*," Russel Van Arsdale Lee, M.D.

Friday Evening, April 12, 1946

"*Atomic Energy and Medicine*," Robert Stone, M.D.

*Thomas de Quincey (1785-1859).*—A frail Oxford student of nineteen walked into a London apothecary's shop and purchased a phial of "tincture of laudanum." This was De Quincey's first acquaintance with opium, which had been recommended to him for neuralgia. Besides opium addiction, he suffered from a psychosis, from tuberculosis, and colonic toxins, the result it was believed of copious tea drinking. "The Confessions of an English Opium Eater" is said to have introduced many subsequent addicts to opium, even to the present day.—Warner's *Calendar of Medical History*.

## COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

#### Survey of Hospital Needs in California

A proposed survey of hospital needs of the State, required for the State to qualify for an estimated \$1,990,000 annually in Federal construction grants, received favorable recommendation by the Assembly Committee on Public Health, at the special session of the California Legislature.

The survey would be made by an advisory council of 25 persons appointed by the Governor who would work in co-operation with the State Department of Public Health. Sponsor of the measure, Speaker Charles W. Lyon, Beverly Hills, said the Federal funds would be made available for construction and improvements of publicly owned and non-profit private hospitals.

Speaker Lyon said the survey has the backing of the Association of California Hospitals and the California Medical Association.

#### Hospital Construction Plans Must Be Approved By State Board of Health

Plans for new hospital buildings and for additions or material alterations to existing buildings must be submitted to the State Department of Public Health prior to beginning construction.

This requirement, part of the general regulations for all hospitals was adopted by the State Board of Health at its meeting December 15, 1945, in accordance with powers granted by the 1945 Hospital Licensing Act.

Regulations governing small hospitals (less than 100 beds) large hospitals (100 beds or over) and temporary regulations pending the adoption of minimum fire safety standards for hospitals were also adopted. The regulations were adopted on the recommendation of the Hospital Advisory Committee appointed by the Governor, of which Dr. John Sharp is chairman.

The regulations on submission of the plans provide that "When construction is contemplated, either for new buildings, additions to existing buildings, or material alterations to existing buildings, the preliminary plans shall be submitted in quadruplicate to the State Department of Public Health for approval."

Twenty-three items which must be included in the plans as submitted are specified.

The regulations also provide that, "All proposed new hospital construction or alterations shall meet the standards of the 1943 Uniform Building Code of the Pacific Coast Building Officials Conference and amendments thereto. The standards of the 1943 Uniform Building Code of the Pacific Coast Building Officials Conference, and amendments thereto, shall prevail in the event of conflict with the rules and regulations of the State Board of Public Health, as pertains to new construction of hospitals.

"After the preliminary plans and drawings have been submitted and tentatively approved by the State Department of Public Health, within 10 days of receipt one copy will be returned to the applicant for corrections. The applicant shall then submit, in quadruplicate, blueprints of working drawings and specifications, with the required revisions, to the State Department of Public Health for comparison with the approved preliminary plans, before contract is let, at which time the State Department of Public Health will formally approve the plans or return same for correction, in which case they are to be resubmitted for final approval. The final approved plans shall then be returned within three weeks.

"It is recognized that change orders may be necessary during the course of construction. Telephone or telegraph communication with the State Department of Public

Health is required and approval or rejection will be given within a reasonable time on all change orders affecting the health and/or safety of the patient. This approval will be confirmed in writing by both the architect and the State Department of Public Health."

#### State Army Hospital to Be Used by Veterans' Administration

The Army Birmingham General Hospital, Van Nuys, turned over 200 beds to the Veterans' Administration on February 11, it was announced by Col. E. K. Wright, deputy administrator for California, Arizona and Nevada.

The hospital will be used for veterans suffering from pulmonary tuberculosis.

An additional 200 beds will be made available within thirty days, it was learned.

Arrangements for use of the hospital were made with the Surgeon General of the Army. It had been originally planned to allocate space for tubercular veterans in the Navy hospital at Corona.

The Navy, however, found itself unable to handle the patients, and arrangements were then made with the Army. The Veterans' Administration will use the beds at the Corona hospital for other cases.

Birmingham Hospital will be staffed by doctors, nurses and other personnel drawn from the Veterans' Hospital at San Fernando and other veteran hospitals in the area.

#### Los Angeles May Take Over U. S. Hospital in Torrance

Studies of a plan whereby the county government would acquire the Los Angeles Port of Embarkation Hospital at Torrance, built during the war by the Federal government at a cost of several millions of dollars, are to be made by County Manager Wayne R. Allen under orders of the Los Angeles Board of Supervisors.

The hospital, which contains 480 beds, with premises completely fenced, will be closed by the armed forces on March 31 next. If purchased by the county it would become an adjunct to the Los Angeles County General Hospital, which for some time has been crowded to capacity.

The proposal to buy the government institution was presented to the Board of Supervisors by Raymond V. Darby of Inglewood.—*Los Angeles Times*, February 18.

#### Address on Atomic Outlook Before Annual Meeting of California Hospital in Los Angeles

Application of atomic energy in the field of medicine was discussed on February 1, by Col. Stafford L. Warren, one of the scientists assigned to the atomic bomb project, before the California Hospital medical staff at a dinner meeting at the University Club.

Dr. William H. Olds, chairman of the staff, presided at the session which marked the 25th anniversary of the acquiring of the hospital by the Lutheran Hospital Society of Southern California.

A shortage of hospital facilities, estimated at a minimum of 4,290 beds in the city, was discussed by Ritz E. Heerman, superintendent of the hospital.

Awards were presented to 20 physicians who have served at the hospital more than 25 years, while the staff presented a gold watch to Dr. Benjamin H. Hager, retiring chief of staff.—*Los Angeles Times*, February 2.

#### Army Will Help Build 80 Veterans' Hospitals Hundreds of Thousands of Beds Provided in \$448,000,000 Two-Year Construction Program.

The Veterans' Administration on February 16, enlisted

the aid of the Army Engineers Corps to speed work on 80 new hospitals, estimated to cost \$448,000,000.

Gen. Omar N. Bradley, Veterans' Administrator, called it the "largest construction program of its kind in history."

He announced the Army coöperation while detailing measures taken to care for sick and wounded veterans during his first six months as administrator.

General Bradley's outline came on the eve of a meeting of the executive committee of the American Legion at Indianapolis. He had planned to attend, Bradley said, but changed his mind when John Stelle, Legion Commander who has been critical of his administration, in an invitation telegram promised him "a most respectful hearing."

"I don't think I should be put on trial by any one group," Bradley commented. "I am responsible only to President Truman."

#### Two-year Construction

On the hospital work, the Engineers will take over a large part of the construction, and with their help General Bradley said, the job can be completed in 18 to 24 months.

Three of the new hospitals are under construction and funds are available for 47 others. Completion of all will give the Veterans' Administration 183 permanent-type hospitals with 151,500 beds. By 1975 it is estimated 300,000 beds will be required.

Construction of the hospitals costing from \$2,500,000 to \$10,000,000 each, should not conflict with the Administration's program of 2,700,000 new homes by the end of 1947, Bradley said.

#### Temporary Measures

Bradley listed these measures to alleviate present and prospective bed shortages pending completion of the hospitals:

The Veterans' Administration has taken over and operates five Army hospitals and has started action to obtain 13 others, including one from the Navy.

The Navy has agreed to give veterans' 9,875 beds in its hospitals and provide staffs. Secretary of War Patterson has agreed to use 10,000 beds in Army hospitals but could not promise to staff all facilities.

Sixty-three medical schools have agreed to supply consultant visiting staffs and residents.

#### COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

##### Los Angeles County General Hospital Issues Call for Nurses

With a near-record load of 3,190 patients and prospects for a gradual increase, the nation's largest hospital—Los Angeles County General—on February 14, issued a nation-wide call for more nurses as those on duty continued to work a six-day week.

"We have a dire need for additional nurses," said A. W. Silver, personnel manager at the hospital, "and we are in a position to offer any professional nurse the best in pay, living conditions and opportunity." . . .

Any qualified nurse can file for a graduate nurse's position at the hospital any time she wishes, and to those who are now nursing in any section of the nation who wish to settle in Southern California, the offer presents an unusually attractive picture.

As to housing, for instance:

"If our nurses 'live in' they are given full housing fa-

cilities," said Silver. "This includes three meals a day and their personal and uniform laundry.

"They are paid \$165 per month for a five-day week, 40 hours per week and no split shifts. This pay does not include their maintenance of \$40 per month, however," he said.

There is an attending staff of the finest doctors in the county and the schools of the institution are included for the nurses.

Each nurse is given two weeks' vacation with pay in a centrally-located hospital which is near the beaches, mountains and shopping center. They are given an average of 12 holidays per year with pay, sick benefits and, if a nurse doesn't utilize the 100 per cent of her sick pay or any portion of it, the time is added to her following year's vacation period.

There are no bedside duties, only professional nursing services are required and nurses will be working in the largest county hospital under one roof in the United States and one equipped with the most modern appurtenances. All services are included, such as treatment of psychopathic cases, communicable diseases and tuberculosis.

The hospital's present nursing staff of 332, far below the need of 872 nurses, necessitates a six-day work week at the present time which cannot be remedied—due to the shortage—until the full complement of 540 additional nurses is secured.

Any professional nurse can apply for a position at the hospital at the Civil Service Commission, 102 Hall of Records Building, or by applying to Silver telegraphically or in person at the personnel office of the institution. Nurse Clark also conducts interviews at her desk in the hospital.

#### Alameda County Nurses to Seek Pay Raise

Nurses of Alameda County today joined the parade of union groups seeking wage increases and improved working conditions.

The recently organized Nurses' Guild of Alameda County, established within the Alameda County Nurses' Association, has prepared negotiating requests to be presented to the East Bay Hospital conference, consisting of all hospitals of Alameda County.

The requests cover increased salaries for general staff, surgery and delivery room nurses; length of work week; holidays and vacations; sick leave; meals, room and laundry benefits, and a health program. In addition, a revised schedule of fees for private duty nurses has been approved.

Details of the requests will not be made public until the hospital association has been formally notified, Morris Glickfeld, the guild's business agent, said today.

Oakland's public health nurses, affiliated with the C.I.O. State, County and Municipal Workers' Union, earlier opened a drive to secure higher wages and improved working conditions.—*Oakland Post-Enquirer*, January 22.

## COMMITTEE ON INDUSTRIAL PRACTICE

#### California Legislature Enacts Bill to Cover Unemployment Through Illness

The Senate on February 13, gave final passage to the amended Shelley bill providing unemployment disability insurance benefits for 2,600,000 California wage earners and salaried folk covered by the unemployment insurance system. It now goes to the Governor for approval.

Introduced by Senator John F. Shelley of San Francisco, the bill was high on the list of measures urged for adoption by Governor Earl Warren during the "reconversion" special session. It was bitterly opposed by representatives of industrial, business and insurance groups, and was attacked as an opening wedge for compulsory "health insurance."

#### No New Cost

Payment of benefits caused by unemployment due to accident or illness will not entail added cost upon either employer or employee, according to the Governor, Shelley and other proponents. They have asserted that unless the State uses this money, which is now theoretically in the United States Treasury, the Federal Government is likely to use it as a subsidy to help the unemployment funds of poorer states, especially in the South.

The 1 per cent now deducted from the employees' pay will be placed in a special unemployment compensation disability fund while the employers' contribution will continue to go into the unemployment insurance fund and be sufficient to sustain it. Payment of benefits from the new fund will not begin for eighteen months. —*San Francisco Examiner*, February 15.

#### Medical Fees Group Starts Drafting Proposed Schedule

Attempts to secure the adoption of a satisfactory medical fee schedule to apply in postwar compensation cases in California were reported as making considerable progress.

A sub-committee, which is composed of Dr. Lester Newman of the State Compensation Fund, chairman; Richard Quigley of California Casualty Indemnity Exchange, and Dr. Nelson Howard of the California Medical Association have been at work to formulate a definite schedule. The present schedule of the California Medical Association served as the model for the committee and it is expected that the draft as presented by the sub-committee will be scrutinized in detail by the entire group when it is finally presented.

It is reported that California physicians are anxious to include in the postwar schedule the 15 per cent increase over the pre-war fees which is now used in the war emergency program.—*San Francisco Underwriter's Report*.

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

**American Psychiatric Association Gives Solid Backing to General Bradley in His Program for Psychiatric Care of Veterans, Stating He Has Sought and Acted Upon Best Professional Advice Regardless of Politics**

Solid backing of General Omar Bradley, Veterans' Administrator, and Major General Paul R. Hawley, his surgeon-general, came officially today from the American Psychiatric Association, representing all the psychiatrists in the country. General Bradley's policy of locating new veterans' hospitals as near as possible to the great and successful centers of medical care, on the basis of veterans' needs, instead of on the basis of political patronage, was specifically endorsed by the Association through its President, Dr. Karl M. Bowman, Professor of Psychiatry at the University of California, San Francisco, California.

The American Psychiatric Association asserted that the best medical and psychiatric care for the veterans could be provided by the policy as outlined by General Bradley and Major General Hawley, and demanded that nothing be allowed to interfere with the execution of this plan to endanger the best possible scientific care for the veteran.

The official statement of the American Psychiatric Association called attention to the fact that the Veterans' Administration psychiatric facilities had in the past been located through references from chambers of commerce and through political pressure groups who lost sight of the fact that only near the great medical centers could the best veterans' care be developed.

It was pointed out that as a result, there are today numerous small veterans' hospitals in inaccessible places, to which suitable medical and nursing personnel cannot be attached, and which are largely removed from the possibility of consultation with the most progressive medical centers.

"The Veterans' Administration has suffered greatly at the hands of politics, both in Congress and on the outside of Congress," said Dr. Bowman. "It augurs well for the future care of veterans that General Bradley and those directly under him have shown no disposition to yield to such political pressure."

Heralding the new emphasis placed by the Veterans' Administration on the medical needs of the ill veteran, the official statement said "Deans' committees have been set up in many centers to provide consultative service to the existing veterans' hospitals and those to be established. A new salary scale designed to secure the best full-time physicians, as well as consultants, has been provided, and the out-patient service is being rapidly developed and improved. The institutions are again being referred to as hospitals instead of 'facilities,' a change which it is hoped will be followed by the appointment of medical superintendents instead of lay 'managers'."

"The American Psychiatric Association has been greatly pleased with the co-operative attitude of General Bradley and General Hawley in working out plans for the Veterans' Administration to care for psychiatric patients," asserted Dr. Bowman, and he went on to say that General Hawley had consulted with the outstanding psychiatrists of this country in appointing Captain Daniel Blain as head of neuropsychiatric work in the Veterans' Administration, and is satisfactorily backing all specific recommendations to improve the care of psychiatric patients.

**Military Clippings.**—Some news items of a military nature from the daily press follow:

#### Army Commands U. C. Hospital Work

Berkeley, March 4.—A certificate of appreciation from the Surgeon General of the Army in praise of the work of the 30th General Hospital, staffed by University of California Medical School faculty members, has been received by President Robert G. Sproul. The 30th General Hospital was in England, France and Belgium.

The certificate states in part: "By its (the University's) patriotic endeavor it unselfishly sponsored, organized and staffed the 30th General Hospital thereby dedicating itself unsparsingly to the service of its country. By its experience and skill it reduced the mortality of our troops to a record unequalled by any nation in the annals of war. . . . The service, co-operation and loyalty of this unit, under circumstances never before encountered in the long history of conflicts is worthy of the highest praise and its achievements are an inspiration to all."—U. C. *Clip Sheet*, March 4.

#### New S. F. Branch Offices Speed Veterans' Program

General Omar N. Bradley's plan of decentralization for operation of the Veterans' Administration should be completed here by August, Col. Edwin K. Wright, acting

deputy administrator for California, Nevada, Arizona, Hawaii and the Philippines said today on the opening of new area offices at 49 Fourth St., San Francisco.

Immediate supervision over hospitals, homes, regional and contact offices and the determining of local policy is the function of the branch office. Later, as the decentralization progresses, it will take over pension, insurance and other matters to accelerate services to all veterans in the area, he explained.

Admitting that local operations have been bogged in some instances, he disclosed in January the San Francisco regional V.A. office received more applications from veterans in Northern California for education and training than the total number of all claims it acted upon in the 23-year period between world wars.

Daily the backlogs are being reduced, General Bradley's trouble-shooter said.

Colonel Wright said the decentralization is being carried out as fast as possible with the minimum of disruption. Space limitations and personnel shortages, not fully overcome yet, have hindered operations.

No immediate plans for more V.A. hospitals in this area were foreseen by Colonel Wright, despite a population shift which promises to give California a veteran population of one and a half million.—*San Francisco News*, February 9.

#### Military Deaths in World War II

Since the Nazis plunged the world into war with their invasion of Poland in September, 1939, many millions of men have lost their lives in battle. Just how great the military loss of life has been in World War II probably will never be known with great accuracy. For many of the countries there are only vague statements regarding casualties. This applies even to some of the major belligerents. In fact, the United States and the British Empire are the only major powers for which official and fairly complete statements of battle losses are available. Consequently, any figures on the aggregate of military casualties for World War II are at best considered estimates.

From a review of the published data obtained through a wide variety of sources, some of them conflicting, it is estimated that the combat losses\* of the belligerents in World War II are of the order of 9,500,000 to 10,000,000. The actual figure cannot be much less; it may be somewhat higher. Axis losses, estimated conservatively at about 5,200,000, were appreciably greater than those of the United Nations, whose battle toll is estimated to have been in the neighborhood of 4,500,000.

Germany's military losses, estimated at 3,250,000, have been the heaviest of any country in the war. They were considerably greater than those of Japan, her major Axis partner. It is estimated that the Japanese lost about 1,500,000 men. Italian combat losses were probably 150,000 to 200,000. The aggregate losses for Germany's other satellites are estimated to have been 225,000. Of this total, Rumania's losses account for about 100,000, Hungary's for about 75,000, and Finland's for about 50,000. Bulgaria's losses were insignificant as compared with those of the other Axis countries.

On the United Nations side, Russian losses were the heaviest by far. They are estimated at approximately 3,000,000, or about two-thirds of the total combat losses suffered by the Allies. The Russian losses are thus estimated to be slightly less than those sustained by Germany. The second highest military toll among the United Nations was borne by the British Empire, whose battle dead are estimated at 375,000 to 400,000. The United States was next in rank among the Allies with respect to battle deaths. The final total of our losses on all fronts of World War II is not yet established. This includes an allowance for deaths among those wounded in action and those still carried as missing on our casualty lists.

The battle deaths of our other European Allies are estimated at nearly 450,000, excluding deaths incurred by forces of the underground. French losses, including those of the Free French, are officially estimated at 167,000, but to this figure may properly be added the many underground fighters among the 100,000 French civilians executed by the Germans between 1940 and 1944. Poland's losses amount to about 125,000 including the deaths in

\* Unless otherwise stated, the term *losses* throughout this article refers exclusively to deaths in action or from battle wounds in military, naval, or air forces.

the Polish forces fighting alongside the Allies after the collapse of their country. This excludes fighters of the Polish underground. Death losses of 15,000 to 20,000 were claimed in the battle of Warsaw in 1945. Yugoslavia's toll during her guerilla warfare against the Germans and Italians is estimated to be in the neighborhood of 75,000. Greek losses are estimated at 50,000. The Belgians report over 7,000 combat deaths, the Dutch, more than 6,000 in the five days of fighting in May, 1940, and the Norwegians about 1,000. Deaths of underground fighters in some of these cases exceeded those of men in uniform. China's military deaths since Pearl Harbor are conservatively estimated as 250,000.

Available details regarding British Empire losses are of great interest. Of the nearly 400,000 combat dead, more than 250,000, or two-thirds of the Empire's total, were natives of the United Kingdom. Canada's losses of more than 35,000 were next heaviest. Australia lost over 25,000 men, New Zealand more than 10,000, South Africa about 7,500, and India nearly 30,000. Deaths among fighting men from the other British colonies totaled nearly 10,000 in World War II.

A large part of the death toll in the Empire forces was accounted for by losses among naval and air personnel. The battle deaths in these two branches exceeded 100,000, or more than one-fourth of the Empire's total. British Navy losses were slightly over 50,000, and an additional few thousand men were lost in battle by the naval forces of Canada and Australia. The bomber command of the Royal Air Force lost more than 40,000. Canada's losses in the air made up nearly half, and Australia's about a third of their total deaths in combat.

The total battle toll in World War II was appreciably greater than that in World War I. Death losses in the earlier conflict are not accurately known, but most of the estimates are of the order of 8,000,000. This is 1,500,000 to 2,000,000 less than the estimated number of 9,500,000 to 10,000,000 for World War II. For the European theater, battle losses in the two World Wars are about equal. In World War I, practically all the estimated 8,000,000 war deaths were sustained in the fight in European territory and in the Atlantic, and only a few thousands elsewhere, whereas in World War II, losses in these areas were about 8,000,000 and losses in the Asiatic and Pacific theaters exceeded 1,500,000 men. During World War I, military deaths were about equally divided between the Eastern and Western fronts in Europe, but in World War II, losses on the Eastern Front, estimated at about 6,000,000, were much the heavier.

The comparative toll of the two World Wars differs greatly for most of the major belligerents. In some cases it is difficult to make accurate comparisons because the national territories were not identical in the two wars. American losses in World War II were about six times as high as in 1917-1918. Russia's losses in World War II were unquestionably higher than in the earlier conflict, although exact comparison is difficult because Russian armies in the first World War comprised large contingents drawn from a territory forming part of pre-1939 Poland, the Baltic countries, and pre-1939 Rumania. If allowance is made for this, Russian losses in World War II appear to be twice as great as in the earlier conflict. German losses in the war just ended were also much higher than in 1914-1918. Again allowing for differences in area due to boundary changes, World War II losses for Germany are estimated to be about 50 per cent above those of the last war. Because of the radically different nature of the fighting in Western Europe in the two World Wars, British Empire losses in the recent war were less than half those in the earlier conflict. This does not apply, however, to naval losses which were appreciably heavier in the recent conflict than in the first World War. For the French, the contrast between the two World Wars is even greater than for the British. In the quick defeat of France in 1940, about 125,000 of her fighting men were killed and subsequent losses among French fighters in various theaters amounted to less than 50,000. Consequently, the total of French losses in World War II was less than one-eighth of that sustained in 1914-1918. Italy's losses likewise were much smaller in the second World War than in the earlier conflict. Probably less than one-third as many Italians were killed in the recent war as in World War I. Rumania and Hungary also lost fewer men than in the earlier war.

Japan presents by far the most striking contrast with respect to military losses in the two wars. She was

actually only a nominal ally in the first war, and her combat losses amounted to a few hundred, incurred in grabbing former German-held territories in Asia and in the Pacific. Consequently, her losses of approximately 1,500,000 soldiers and sailors after Pearl Harbor are incomparably greater than her losses in World War I. A similar contrast exists with respect to China, whose military contribution in the first World War was insignificant, partly because of her military weakness and partly because there was little fighting in Asiatic territories.

\* \* \*

World War II was by far the most destructive in human history in terms of loss of life, both military and civilian, and of damage to social and economic institutions. Recovery from this disaster will be a long and painful process. Dislocations arising from the conflict will plague the world for decades to come. Unless the threat of war is removed in the new atomic age, the prospects are bad indeed for our civilization.—*Statistical Bulletin*, Vol. 27, No. 1, January, 1946.

#### Veterans Medical Care in California

Medical service on a home-town basis will be provided to eligible veterans soon after February 1 in California. This results from the signing of a contract by the Veterans' Administration and the California Physicians' Service. To General Omar N. Bradley, the able head of the Veterans' Administration, credit is due for adoption of this workable plan.

California already has 1,300,000 ex-service men and women. Of World War II veterans, nearly 70 per cent claim service-connected disabilities. The great majority are not ill or incapacitated enough to require separation from their homes and jobs in veterans' hospitals, but do need the best in medical service as out-patients, and are entitled to it without delay, red tape or personal cost.

California Physicians' Service, whose members will be paid on a fee schedule set up in the government contract, was organized by the California Medical Association. For several years, C.P.S. has provided voluntary, prepaid medical care to civilians desiring the service, and the Veterans' Administration contract broadens its activity considerably.

That the doctors in this State have an organization so they can provide service on a home-town basis, without government regimentation of either the veterans or the medical profession, should prove beneficial to all.—*Redlands Facts*, January 21.

#### New Medical Plan Ordered For Veterans

*New Non-Military Medical Corps to Aid U. S. Veterans*

Washington.—(UP)—General Omar N. Bradley, victor in his first statewide battle, today ordered into operation a complete new deal in medical care for veterans.

#### Wins Victory

Bradley won his victory late yesterday when President Truman, over protests of the Civil Service commission, signed a bill authorizing an independent, non-military medical corps for Bradley's Veterans' Administration. Bradley said he was setting it up immediately.

He believed the new organization, providing salaries up to \$12,000 and higher professional standards, would attract a flood of top rank medical men. The agency is now critically understaffed.

Bradley had ready full page advertisements for insertion in medical journals, advising the profession of new opportunities in veterans' hospitals.

His aides said scores of doctors had already signed their intention to join V.A. as soon as the bill was effective. They have been promised higher pay, a chance at research, and medical standards equal to those of universities.

The president approved the medical department bill against strong advice of civil service, which deplored its abolition of civil service status and elimination of veterans preference.—*Merced Sun-Star*, January 4.

O, America, because you build for mankind I build for you.

—Walt Whitman, *By Blue Ontario's Shore*.

She [America] of the open soul and open door,  
With room about her hearth for all mankind!

—J. R. Lowell, *Commemoration Ode*.

## MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

## NEWS

### Coming Meetings\*

*California Medical Association.* Session will convene in Los Angeles. Headquarters, Hotel Biltmore, 5th and Olive Sts. Dates of meetings: Tuesday, May 7-Friday, May 10, 1946.

*American Medical Association.* The next annual session of the American Medical Association will be held in San Francisco, July 1-5, 1946. (Monday-Friday, inclusive.)

### The Platform of the American Medical Association

The American Medical Association advocates:

1. The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.
2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.
3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.
4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.
5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.
6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.
7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.
8. Expansion of public health and medical services consistent with the American system of democracy.

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in CALIFORNIA AND WESTERN MEDICINE for December, 1939, on pages 394-395. For subsequent comment, see J.A.M.A., June 24, 1944, pp. 574-576. Also, August, 1945, CALIFORNIA AND WESTERN MEDICINE, pp. 61-62.) On p. 61 (C.M.A.) and p. 62 (A.M.A.)

### Medical Broadcasts\*

#### The Los Angeles County Medical Association:

In March KFAC will present broadcasts on Saturdays at 15:15 a.m.; March 2, 9, 16, 23, and 30.

The Saturday broadcasts of KFI are given at 9:45 a.m., under this title, "The Road to Health."

#### "Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see J.A.M.A.

\* In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In CALIFORNIA AND WESTERN MEDICINE, some rosters appear in every second or third issue.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

### Pharmacological Items of Potential Interest to Clinicians\*:

1. *More on Journals:* British Medical Association will publish *British Journal of Pharmacology and Chemotherapy*, edited by J. Gaddum, 4 issues yearly, at 25s. Better get! Current subscriptions and back files of Russian medical journals may be ordered from Mezhdunarodnaja Kniga, Kuznetski most 18, Moskva, U.S.S.R., or from Four Continent Book Corp., 253 5th Ave., New York City, at following prices: *Acta Physicochemica*, \$10; *Biochemistry*, \$5; *Bulletin Experimental Biology and Medicine*, \$5; *Clinical Medicine*, \$5; *Hygiene and Sanitation*, \$1.30; *Journal Microbiology, Epidemiology and Immunology*, \$6; *Medical Parasitology*, \$4; *Neuropathology and Psychiatry*, \$6; *Ophthalmology*, \$6; *Pediatrics*, \$5; *Problems of Tuberculosis*, \$5; *Problems of Neurosurgery*, \$5; *Pharmacology and Toxicology*, \$4; *Soviet Medicine*, \$5; *Stomatology*, \$3, and *Surgery*, \$6. Science seems to have improved format and policy.

2. *Special Reports:* O.S.R.D. promises 2,500 page report on screening studies on anti-malarials. Office of Medical Information issues O. Temkin's well organized *Report on the Medicinal Treatment of Filariasis Bancrofti* (Nat. Res. Counc., Washington, 1945, 69 pp.). Office of Publication Board, Department of Commerce, issues mimeo series on recent German work: F. J. Curtis & Co., *Pharmaceuticals and Insecticides at I. G. Farben plants Elberfeld & Leverkusen* (Off. Pub. Bd. Rep. P.B. 237, 1945, 127 pp., 75c); A. M. Horack & Co., same title for Hochst am Main (P. B. 241, 38 pp., 25c); K. C. Blanchard, *Evaluation of Antimalarials* (P. B. 246, 20 pp., 25c); I. C. Kleiderer & Co., *Supplementary Report on Elberfeld* (P. B. 248, 141 pp., \$1); I. C. Kleiderer & Co., *Pharmaceutical Activities at Hochst am Main* (P. B. 981, 139 pp., 75c).

3. *Enzymes:* S. J. Bach well reviews biological methylation (*Biol. Rev. Cambridge Philosoph. Soc.*, 20:158, 1945). A. L. Lehninger shows activation of fatty acid oxidation is specific function of adenosine triphosphate, sensitive to sulhydryl reagents, requiring free carboxyl group, and diphosphopyridine nucleotide as component of oxidase system (*J. Biol. Chem.*, 161:437, 1945). D. E. Green & Co. discuss transaminases and indicate pyridoxal phosphate as prosthetic group (*Ibid.*, p. 559). K. E. Paschkis & Co. observe inhibition of cytochrome oxidase by thiouracil and sulfonamides (*Proc. Soc. Exp. Biol. Med.*, 60:148, 1945).

4. *Cancer:* Thirty reports covering virus approach, carcinogenesis, enzymes, diet and chemotherapy appear in *Cancer Symposium* (A.A.A.S., Smithsonian Bldg., Washington 25, 333 pp., \$4). D. T. Thomas discusses mutation of healthy to malignant cell (*Nature* 156:738, Dec. 22, 1945). H. Ulrich warns against danger of leukemia among radiologists (*N. E. J. Med.*, 234:43, Jan. 10, 1945). B. Scharrer describes tumors from nerve section in insects (*Proc. Soc. Exp. Biol. Med.*, 60:184, 1945).

5. *Interesting:* W. Shepard vigorously and intemperately criticizes V. Bush's *Science, the Endless Frontier* and Committee to Support the Bush Plan (*Science*,

\* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

103:65, Jan. 18, 1946). F. D. MacCallum and J. A. R. Miles offer experimental evidence that infective hepatitis is caused by bowel excreted virus (*Lancet* 1:3, Jan. 5, 1946). H. Eagle shows spirochaeticidal action of acid substituted phenyl arsenoxides is influenced by proportion of iron and free acid with undissociated free acid more strongly bound by parasite (*J. Pharmacol. Expt. Therap.*, 85:265, 1945). H. Shay & Co. suggest alkyl sulfates as gastric mucigogues for peptic ulcer (*Science* 103:50, Jan. 11, 1946). E. G. Williams and F. W. Oberst give detailed data on biological and psychological effects in cycle of morphine addiction (*Pub. Health Rep.*, 61:1, Jan. 4, 1946). F. Hawking plasmodia in tissue culture (*Trans Roy Soc. Trop Med. Hyg.*, 39:245, 1945). R. A. Gortner, Jr. & Co. show sugars may increase tooth destroying properties of phosphoric, citric and other acids (*Arch. Biochem.*, 8:405, 1945). J. D. Stone and F. M. Burnet report iodine vapor 0.1 ppm. vol. of air destroys infectivity of influenza virus (*Austral. J. Expt. Biol. Med. Sci.*, 23:205, 1945). G. E. Cartwright & Co. suggest chronic infection anemia due to iron fixation in tissues involving reticulo-endothelial system (*Science*, 103:72, Jan. 18, 1946). A. R. Behnke reviews absorption and elimination of body gases in relation to fat and water content and decompression sickness (*Med.* 24:359, 381, 1945). Our A. Ruskin and P. Rockwell discuss influence of dose and volume on circulation time (*Proc. Soc. Expt. Biol. Med.*, 60:40, 1945). Our E. J. Roth, E. B. Fernadez and G. Drager describe prevention of end-bulb neuromata in painful amputation stumps (*Ibid.*, p. 200). Our A. E. Hansen reviews disturbances of lipid metabolism in children (*Southern Med. J.*, 39:32, 1946).

#### "Doctors at Home"—N.B.C. Broadcasts

*Broadcast by the Independent Radio Stations Affiliated With the NBC Network and the National Broadcasting Company, in Coöperation With the American Medical Association.*

"We have chosen the title *Doctors At Home* as an indication of our gratitude for peace and our thankfulness for the return of our greatly missed and much needed family physicians who, in increasing numbers, are laying aside their uniforms to take up the postwar problems at home.

"Among these problems will be the distribution of physicians in response to need, the extension of public health services, the improvement of health in our school children, the maintenance of physical fitness, and the advance of medicine, both preventive and curative.

*Doctors At Home* will continue to work as they always have, for the two principal purposes of the doctor and the doctor's organization, the American Medical Association. These purposes are the promotion of the science and the art of medicine and the betterment of the public health." Consult local listings for day and time.—W. W. BAUER, M.D., Director, Bureau of Health Education, American Medical Association, 535 N. Dearborn, Chicago.

**U. C. and Stanford Will Aid S. F. Veterans' Hospital.**—Stanford and California Medical Schools will coöperate with the Veterans' Administration in providing consultants and resident physicians for San Francisco's Veterans' Hospital.

Major General Paul B. Hawley, acting chief medical director of the agency, announced on January 26, a committee from the two schools also will judge professional standards in the hospital.

Members of the committee from Stanford are Drs. Emile F. Holman, chairman; Arthur L. Bloomfield;

George S. Johnson and Carleton Mathewson; junior California members are Drs. LeRoy C. Abbott, Karl M. Bowman, William J. Kerr and Howard C. Naffsiger.

Deans of the schools, Dr. L. R. Chandler of Stanford and Dr. Francis S. Smyth of California, are ex-officio committee members.

Fifty of the Nation's 75 Class A medical schools are coöperating in the program throughout the country.

**Stanford Medical School Receives Navy Commendations.**—Receipt of two Navy commendations for distinguished service by the School of Medicine in educating V-12 students during the war, was announced by Donald B. Tresidder, president of the university, on January 28.

One commendation was presented to Dr. Loren R. Chandler, dean of the medical school. The second credited Stanford with an important contribution to "immense expansion" of the Navy medical corps through the training of specially selected enlisted men."

**Plans for Coöperation Between Teaching Institutions and Veterans' Hospitals.**—The *J.A.M.A.* for Dec. 15, 1945, on page 1100, gave the details of the plans of coöperation between teaching institutions and veterans' hospitals and also for the use of civilian practitioners in the care of the veteran. The description includes the appointments to be given to civilian physicians and the terms of their employment. There appeared also letters that have been sent to the deans of medical colleges, who will be asked to coöperate fully in the development of the plan. Then followed a statement of General Hawley's plan for the immediate future for the staffing of veterans' hospitals and for coöperation with teaching institutions. There will probably have to be some variations made in the plan for individual hospitals according to the necessities, but the plan should work if:

1. Those in charge of administration of hospitals want it to work;
2. There is coöperation between hospitals, medical schools and consultants appointed by the Surgeon General of the Veterans' Administration.

The object of these changes is to give better care to individual patients by bringing into the veterans' hospitals the best trained men obtainable in civilian practice of medicine. This can be done so far as consultants are concerned by putting consultants on a basis which will allow them to devote part of their time to veterans' hospitals and part to their own private practice and teaching.

It is realized by the Surgeon General that it was the complete coöperation of the civilian doctor fitted into his proper sphere of interest and ability in the Army that made the service to the G. I. outstanding in the field of military medicine and surgery. It is planned that this same type of service will be continued in the Veterans' Administration the only difference being that neither the doctor nor the patient will be in uniform.

**Red Cross Blood for Civilians.**—The American Red Cross will begin on February 3, providing civilians in Los Angeles hospitals with whole blood. It is a service the agency will make without cost to those who need transfusions, hitherto a costly incident to serious illness or injury.

Los Angeles will be the first community in the nation to have this service. As was the case in war years, donations to the Red Cross Blood Bank will be voluntary and without remuneration. Embarking in this

service, the Red Cross demonstrates that it can be as useful in peacetime as in war.

At the inception of the program blood will be taken by the Red Cross for exclusive use by the Los Angeles County General Hospital, but ultimately the program embodies supplying of whole blood—typed and tested—to other hospitals, both civilian and military and to physicians in the county. It is a move which carries the indorsement of the Los Angeles County Medical Association.

Hospitals may continue to make a service charge for administering the blood, but the patient will bear no cost for the blood itself.

Members of the community should respond as heartily to this call for assistance to their neighbors at home as they did for their troops overseas.—Editorial in *Los Angeles Times*, February 3.

**President Truman Heads New National Foundation to Combat Arthritis.**—With President Harry S. Truman as its Honorary Chairman, a new national foundation to combat arthritis was announced on February 10, at a special reception and conference at the Blackstone Hotel in Chicago. Mr. Louis Kranitz, St. Joseph, Missouri, Chairman of the National Campaign Committee, declared that two and one-half million dollars is the goal being sought for the establishment of the National Arthritis Research Foundation, with its main buildings to be located in Hot Springs National Park, Arkansas.

The Foundation is being established as a national and independent center for studying the causes and treatment of rheumatic diseases.

**American Academy of Pediatrics.**—Written examination will be under a Monitor, on March 22, 1946. Oral Examination San Francisco, California, at the time of the meeting of the A. M. A. (July 1-5) If sufficient applications are received before March 22 to warrant such an examination. The application fee of this board will be raised to \$100.00 on May 1, 1946.

**Public Health League of California: (Northern District) Annual Meeting.**—The annual meeting of the Northern District of The Public Health League of California, was held on Wednesday evening, February 20, 1946, at the El Jardin Restaurant, 26 California Street, (near Market), San Francisco. Dinner at 6:30 P. M.

The Nominating Committee submitted the following recommendations for officers of the Northern District: David A. Wood, M.D., San Francisco—President; Compton B. Millarr, D.D.S., San Francisco—Vice-President; Charles A. Noble, Jr., M.D., San Francisco—Secretary; Chester W. Johnson, D.D.S., San Francisco—Treasurer.

Councilors: Kaho Daily, M.D.—Richmond; Ergo A. Majors, M.D.—Oakland; Edmund J. Morrissey, M.D.—San Francisco; Ernest F. Soderstrom, D.D.S.—Modesto; Glendon H. Terwilliger, D.D.S.—Oakland; Frederick T. West, D.D.S.—San Francisco; Paul S. Wyne, M.D.—San Francisco.

Auditor: Robert C. Frates, D.D.S.—San Francisco.

Report on the Special Session of the Legislature was made. Dr. Dwight Murray, Trustee of the A.M.A., reported on the national picture as regards Health Insurance.

**War on Disease Show Opened at Los Angeles County Museum on February 17.**—Steps the public

may take to guard against and eliminate six serious ailments were depicted in displays completed for the "War on Disease Show" in the County Museum, Exposition Park.

The show opened, free to the public, as a feature of Disease Prevention Week, which will continue until the night of Feb. 24. Hours of the exhibit are 10 a.m. to 5 p.m., daily, except Sundays, 1 to 6 p.m., and Monday, 12 noon to 5 p.m.

#### Disease Charts

Drawings of microbes, graphs on the city's disease rates, explanations of how plagues spread and suggestions on detecting, treating and curing diseases will be displayed in the exhibits. The miracle drug, penicillin, and equipment used in the war on disease also will be shown.

Arranged by the Community Health Association in cooperation with the city and county health departments and other health agencies, the week will be observed with meetings dedicated to curb of whooping cough, smallpox, diphtheria, tuberculosis, syphilis and gonorrhea.

One of the principal civic meetings will be held Wednesday in the Biltmore with Dr. Walter H. Brown, dean, School of Public Health, University of California, Berkeley, as chief speaker.

In many churches, pastors will talk on the benefits of good health today. "February 18" has been named, "phone your doctor day," as men, women and children are urged to arrange for inoculations and physical examinations.—*Los Angeles Times*, February 17.

**Northern California Union Health Committee.**—The Northern California Union Health Committee was dissolved by action of the Board of Directors. The office closed on February 15, 1946.

Adequate financing had not been provided for continuance of the Committee's activities.

The Board commended the work of the Committee, which resulted from activities sponsored by the California Labor School.

**Institutions Accredited by the American Public Health Association to Give the Degree of Master of Public Health (Diploma of Public Health in Canada) for the Academic Year 1946-47.**—This list is released by the Executive Board of the American Public Health Association as of January 25, 1946, on recommendation of the Committee on Professional Education, and considers those institutions from which requests for accreditation had been received to that date. Additional applications will be acted upon in due course. In the list of nine schools appears the name:

University of California School of Public Health.

**American Public Health Association: 1790 Broadway, New York, N. Y.**—The executive board of the American Public Health Association announces the 74th Annual Meeting of the Association to be held in Cleveland, Ohio, the week of November 11, 1946.

This will be the first full-scale convention of this professional society of public health workers since 1942. In 1943 and 1944, streamlined wartime congresses on public health were held and in 1945, for the first time in its history, the organization held no Annual Meeting.

An attendance of 4,000 is anticipated, representing every state in the United States, Canada, South America and many countries outside this hemisphere.

**Milk Drinking War Veterans Help Break Dairy Records.**—Returning veterans drinking milk in record

quantities have helped raise United States consumption to all-time high levels, according to the Milk Industry Foundation.

Never in the history of the country has there been such a tremendous flow of milk from American farms to so many people. With milk production on farms around four billion quarts a year higher than before the war, the supply cannot keep up with the demand.

"Milk is our most widely used food," the Foundation says, "and the largest single source of cash farm income. Cash from milk is larger than cattle or hogs, over twice cotton income, wheat or eggs and four times tobacco. Farm income from milk for 1945 is expected to exceed three billion dollars when final figures are compiled.

"Milk and its products comprise more than 25 per cent of the foods estimated to be consumed annually by the average American. Consumers use more than 50 million quarts of fresh milk and cream a day," the Foundation says in its annual statistical review of the industry.

"New methods of distribution efficiency developed during the war are popular and surveys show that the every-other-day distribution plan and other economies save consumers one cent or more per quart. The government's farm subsidy makes possible an additional saving to consumers averaging around 1½ cents a quart."

#### MILESTONES OF MILK HISTORY Of Interest to Certified Milk Commissions

- 1611 Cows arrive for Jamestown Colony.
- 1624 Cows reach Plymouth Colony.
- 1841 First regular shipment of milk by rail—Orange County to New York City.
- 1856 Pasteur experiments start.
- 1878 Continuous centrifugal cream separator invented by Dr. Gustav De Laval.
- 1884 Milk bottle invented by Dr. Hervey D. Thatcher, Potsdam, N. Y.
- 1886 Automatic bottle filler and capper patented.
- 1890 Tuberculin testing of dairy herds introduced. Dr. S. M. Babcock perfects test for fat content of milk and cream.
- 1892 Certified milk originated by Dr. Henry L. Colt in Essex County, N. J.
- 1893 Nathan Straus depots for pasteurized milk open in New York City.
- 1895 Pasteurizing machines introduced.
- 1906 Paper single-service container patented.
- 1908 First compulsory pasteurization law (Chicago) applying to all milk except that from tuberculin tested cows.
- 1911 Automatic rotary bottle filler and capper perfected.
- 1914 Tank trucks used for transporting milk.
- 1924 Insulated milk tank cars introduced.
- 1932 Methods of increasing Vitamin D in milk made practicable.
- 1933 Fluid milk included in Army ration.
- 1938 Textiles made from milk casein.
- 1942 Wartime milk conservation program inaugurated.

**Press Clipings.**—Some news items from the daily press on matters related to medical practice follow:

#### What Is Adequate Medical Care?

In a recent address, Dr. Roger I. Lee of Boston, President of the American Medical Association, said: "There have been many clarion shouts that medical care in the United States is inadequate . . . But as far as I know no one has attempted to redefine adequate medical care . . .

"In 1936 untrained investigators asked people in a house to house survey if they had adequate medical care. If the people said 'No,' they were recorded as having inadequate medical care. Resulting records were broadcast all over the land and were described as indicative of a melancholy state of inadequacy of medical care and of callous neglect by the medical profession.

"More recently there have been highly colored statements regarding the large percentage of rejections for physical defects in connection with the operation of the Selective Service Act. The figures call for careful examination and considered action. Many of the defects have no relation to medical care, adequate or inadequate.

Nature does not uniformly produce perfect fruit, be it babies, puppies, calves or apples. If children are very near sighted or astigmatic, adequate medical care demands glasses for the correction; but the Army or the Navy decides whether or not it wants such an individual. . . ."

Dr. Lee points out that the rapid advancement in medical science makes what might be considered adequate medical care today completely out of date and inadequate a year hence. For example, sulfa drugs, penicillin, modern obstetrics and countless other medical developments have made what some might claim adequate or inadequate medical care in 1936 wholly out of date. Furthermore, it is altogether probable that the average individual would be incompetent to state whether or not he had adequate medical care, due to his lack of knowledge of medical progress.

With so much ignorance on such an important subject, it is easy for politically minded reformers to propose plans for socialized medicine which are appealing in their unconscious misrepresentation to an uninformed public.—*Mojave Desert News*, January 17.

#### U. S. Medical Gains

Chicago, February 14.—(AP)—Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, declared today American medicine had gone "far beyond" President Truman's recommendations on medical care.

In an address prepared for delivery to the eighty-first annual mid-winter meeting of the Chicago Dental Society, Fishbein listed Truman's health recommendations, and said:

"We have, in fact gone far beyond these recommendations in urging a minimum standard of nutrition, housing, clothing, and recreation as fundamental to good health in any health program."

He added the procedures established for advice to pregnant women and for childbirth care "should be made available to every woman at a price she can afford to pay."

"We have favored suitable hospitalization and medical care for veterans:

"We urge extended, coördinated and intensified research for the advancement of medical science;

"We urge a program of health education with the widest possible dissemination of information regarding the prevention and treatment of disease."

Fishbein said, "all these proposals are extensions of services now being rendered on a somewhat limited scale since they are not equally available in all parts of the United States," and reported the A.M.A. is preparing a health insurance plan "consistent with the principles of the American plan of government."—*Fresno Call-Bee*, February 14.

#### Vivisection Called Painless

Chicago.—(AP)—More pain is inflicted on animals "in one hunting, trapping and fishing season than in all the centuries of animal experimentation," an eminent physiologist declared yesterday. Dr. Anton J. Carlson, University of Chicago distinguished service professor emeritus and temporary chairman of the organizing board of directors of the National Commission for the Protection of Medical Science, said in an address prepared for delivery to the 42nd annual Congress on Medical Education and Licensure "the horrors which anti-vivisectionists portray simply do not exist."

"Much of the 'suffering' alleged in anti-vivisection literature is imaginary," he declared. "Certainly it cannot be immoral to use animals humanely to mitigate human suffering due to disease, as long as we believe animals may be sacrificed for human food and clothing."

"If man is not worth more than the dog, then our efforts to improve man are an error."

Dr. Carlson said many experiments performed on animals result in the mitigation of diseases in man and animals.

"Our efforts toward prevention and control of infantile paralysis would be hopeless, except for the use of some species of monkeys and rodents in detecting and following the polio virus," he said. "And yet, the Anti-Vivisection League of Los Angeles publicly proclaims that 'it does not support the March of Dimes Campaign.'

"When animals under anesthesia are used in medical teaching, they are not allowed to come out of the anesthetic," he added. "Death by anesthesia is certainly not painful."

In another prepared address, Dr. Paul Titus of Pittsburgh, said the two "most pressing" problems of specialized medicine now are "the heavy demands for resi-

dency and other training, and the efforts of hospitals to satisfy these demands."—Sacramento *Union*, February 12.

#### Anesthetics Used in Vivisection

Washington, February 14.—Let those circles which have been agitated over vivisection of dogs take heed—the operations are performed under anesthesia.

A dog in an operating room for experimental purposes receives scientific pain prevention, equal to that given a human who comes under the surgical blade.

That goes for cats, too.

A widespread absence of this information has caused dismay among some people who have been reading gruesome accounts of vivisection.

Take it from the Army and from the Friends of Medical Research, New York Academy of Medicine.

Said the Army: "No research capable of inflicting pain or suffering may be undertaken unless the animals are suitably anesthetized, or other steps have been taken to prevent suffering."

Army research is conducted in connection with recognized medical centers. Rules and regulations of the centers govern the Army researchers.

Says the Friends of Medical Research: "There is always anesthesia in an operation on a living creature. The technique for operating on animals is the same as that of operating on people. This applies even to masking every person in the operating room."

Doctors study dogs to learn about human beings. If conclusions are to be accurate, doctors must provide the same conditions for dogs as they would for persons.

"The law now safeguards all animals used in research. A laboratory dog is prepared for an operation with the care accorded a human being."—San Francisco *News*, February 14.

#### Forum For Doctors Back From War

"The Economics of Postwar Medical Practice" will be discussed at an open forum for physician veterans, under auspices of the San Francisco Physicians' Forum, Monday at 8 p.m. at Mount Zion Hospital Nurses' Auditorium, 2345 Sutter St.

Major Frank F. Furstenberg will be moderator. The panel of physician veterans will be Drs. Cabot Brown, Garnett Cheney and Roy Cohn.

Topics under discussion will include group practices, settling in rural areas in California, hospital insurance, and health insurance. All physicians are invited to attend.—San Francisco *News*, January 25.

#### Former Stirling City Physician, 95, Plans to Resume Practice

Stirling City (Butte County, California.)—January 24.—Dr. A. L. Derbyshire, 95, a resident here for many years, has informed local friends he has returned to San Diego from a hospital in Daly City and expects to resume his practice soon.

Dr. Derbyshire will observe his ninety-sixth birthday on Memorial Day. While here he was physician for the Diamond Match Company.—Sacramento *Bee*, January 24.

#### California "Physicians and Surgeons' Licenses"

Formulating plans for a comprehensive educational program to acquaint the public with the necessity of reading carefully any health insurance or sickness benefit policy before signing it, osteopathic physicians and surgeons from Kern, Tulare and Fresno counties met in Bakersfield February 3, at the Bakersfield Inn. . . .

Following statement was issued:

Many persons are not aware that in California the physician and surgeon certificate is issued as well to doctors of osteopathy (D. O.) as to doctors of medicine (M. D.). Doctors holding the M. D. degree may be graduates of an allopathic, electric or homeopathic school of medicine. Doctors holding the D. O. degree are graduates of an osteopathic school of medicine. The broadest license, entitling the holder to use any and all methods, including medicine and surgery, in the treatment of disease, injuries and deformities, is the physician and surgeon certificate, issued under the provisions of the Business and Professions Code of the State of California. Graduates of any of the above schools who comply with the educational requirements of the Business and Professions Code are eligible to take the examination for the physician and surgeon certificate.—Bakersfield *Californian*, February 4.

## MEDICAL JURISPRUDENCE†

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San Francisco

#### Malpractice: Sufficiency of Evidence; Degree of Skill Required of a Surgeon

A recent case decided by the Supreme Court of the State of Washington may be of interest to members of the medical profession because it involved a detailed consideration of the medical procedures and surgical techniques which were employed during an operation, in order to determine whether or not the operating surgeon had been negligent. The surgeon was absolved of any liability.

In *Fritz v. Horsfall*, 163 Pac. (2d) 148; November 1, 1945, the Washington Supreme Court was presented with the following situation. Mr. F. had contacted Dr. H. in 1943, at which time he complained of heartburn. Dr. H. took x-ray pictures of Mr. F. and advised an operation to remove the appendix and gall bladder. The operation was performed on March 9, 1943, after which the patient remained in the hospital until March 30, at which time he returned to his home in the care of a nurse. While at home the wound discharged bile and at one time during the first part of May, a piece of gauze was pulled from the wound by the patient's mother. The wound continued to discharge until the month of July. During that period of time, the patient suffered from fever and chills, and also coughed and vomited blood and bile.

Dr. H. continued to treat the patient and opened the wound on several occasions, after which the patient stated that he felt better. Thereafter until December 3, 1943, Mr. F. was continuously treated by Dr. H. and returned to the hospital in August for a second operation. During this period Mr. F. was in constant ill health suffering from chill, fever, coughing and great pain when the wound broke open and emitted a quantity of bile and blood. During a conversation with the patient the doctor stated, in speaking of other doctors: "They told me I made a slip"; and then said: "Now, listen, you know that any man can make a slip, but I know I didn't."

On December 3, 1943, Mr. F. traveled to the Mayo Clinic at Rochester, Minnesota, where an operation was performed on him about the middle of December by a member of the staff. A post operation was performed and he was discharged on January 19, 1944, and returned to his home in Seattle. Thereafter Mr. F. made a total of three trips to the Mayo Clinic but continued to suffer constantly from jaundice, fever, chills and infection.

After his return from his last trip to the Mayo Clinic, Mr. F. had a conversation with Dr. H. in which he told the doctor that he had been compelled to go to the Mayo Clinic which cost him "considerable money," and that he felt that Dr. H. would help him; that the doctor replied, "I fully agree with you." Later, when Mr. F. called the doctor, Mr. F. was told that he (the doctor) had done nothing wrong.

Succinctly stated, the foregoing facts formed the background for the malpractice suit which Mr. F. filed against Dr. H. The basis of the suit being, in substance, that Dr. H. had not cured Mr. F. and therefore should be liable for negligence in treating and operating upon Mr. F.

Dr. H.'s testimony is reproduced in the opinion in full, and indicates that he was examined and cross-examined

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

in order to reveal the exact condition of Mr. F.'s gall bladder and the surgical techniques which he employed during the operation. All this with the purpose of determining whether or not he had been negligent.

The Court first announced the general rule of law that, an individual licensed to practice medicine is presumed to possess that degree of skill and learning which is possessed by the average member of the profession in the community in which he practices, and to have applied that skill and learning with ordinary and reasonable care to those who come to him for treatment. Further, that before a physician or surgeon can be held liable for malpractice he must have done something in the treatment of his patient which the recognized standard of medical practice in his community forbids in such cases or he must have neglected to do something required by those standards. Then the court stated the principle upon which the instant case turned; that it is not required that physicians and surgeons guarantee results, nor that the result be what is desired.

Dr. H. then explained with the aid of intricate diagrams and drawings exactly what transpired during the first operation. First he exposed the gall bladder in order to determine whether or not his diagnosis of a diseased gall bladder was correct. Having confirmed this diagnosis, Dr. H. then continued the operation and during the course of the trial and his testimony related to the Court all his acts and reasons therefor.

It was necessary for the witnesses to explain in minute detail all that occurred during the difficult operation because Mr. F., the patient, had alleged that sometime during the surgery Dr. H. had been negligent and as a result Mr. F. had not been cured.

After a parade of expert witnesses both for and against Mr. F., the Washington Supreme Court held in favor of Dr. H.

In holding for Dr. H. the Court stated Mr. F.'s condition following the operation had been due to infection and not to any mistake or carelessness on the part of Dr. H.; that on the other hand, Dr. H. had used great care in performing the operation and administering to his patient's needs after the operation.

Applying the rule that it is not required that physicians and surgeons guarantee results, nor that the result be what is desired, the Washington Supreme Court held that Dr. H. had fulfilled all his obligations; also, that he possessed that degree of skill and learning possessed by the average member of the profession in the community and that in the instant case he had applied that skill and learning with ordinary and reasonable care to Mr. F.

Whereupon the Washington Supreme Court instructed the lower court to dismiss the action.

#### *Roentgenography and Tuberculosis*

Case finding among symptomatic patients cannot be expected to result in a majority of those patients being discovered at a minimal stage; and contact examination among associates of diagnosed patients, although yielding a high proportion of early cases, is limited in its scope, especially among urban residents. Mass roentgenography would appear to be needed if substantial reduction of cases which are advanced at the time of discovery is to be achieved. Berwyn F. Mattison, M.D., Amer. Jour. P. H., Nov. 1944.

Some people have food; but no appetite; others have an appetite, but no food. I have both. The Lord be praised.

—Oliver Cromwell, *Grace*. (attr.)

To make our appetites more keen,

With eager compounds we our palates urge.

—Shakespeare, *Sonnets*. No. cxviii.

#### **Birth Rates—In Relation to Social Factors**

Among women of ages 15 to 49 who at the time of the 1940 census were living with their husbands, but had been married more than once, there were 403 children under 5 years of age per 1,000. Thus, as one consequence of the period of separation between marriages, these women had about 16 per cent fewer children than those whose first marriage had not been broken by the time of the census.

In the case of married women whose husbands were absent from the home for temporary or permanent reasons, the ratio of children under 5 years per 1,000 was just half of that for women married once and with their husbands present. The absence of the husband may be through his employment away from home, or because of hospitalization or confinement to prison; there are, in addition, permanent absences, many of which would in due course lead to legal separation or divorce.

Among the widowed or divorced women, there were evidently some who had not long been separated, for in this group there were 208 children under 5 years per 1,000 women of ages 15 to 49. This is considerably less than half the ratio for married women whose first marriage had not terminated.

Apparently, early marital separations are a factor of some significance in the low birth rates usually found in cities. This is made evident by the finding that in urban centers the ratio of children under 5 years per 1,000 women who had ever married—including those who had been widowed, separated, or divorced—is 7.6 per cent less than that for women who were still married and living with their first husband at the time of the census; whereas the corresponding difference in rural farm areas was only 3.3 per cent. This situation reflects the greater frequency of marital separations in the city than in rural sections. Thus, in urban communities, 28 per cent of the native white women of ages 15 to 49 were widowed, divorced, remarried, or separated from their husband, while the corresponding figure for farm areas was only 21 per cent.

Compared with the other geographic areas of the country, the West has not only the lowest ratio of children under 5 years per 1,000 married women, but it also experiences the largest reduction in birth rates as a result of marital separations. Thus, the ratio for all women who had ever married—namely, 412 per 1,000—is 8.4 per cent less than that for women whose first marriage was still enduring in 1940. In this regard, the North Eastern and the North Central States had the smallest loss, about 6 per cent, while for the South it was 6.6 per cent.

Although the frequency of widowhood among women at the child-bearing ages is decreasing, there has for years past been a contrary, upward trend in marital terminations by separation or divorce, tending to reduce the birth rate. If war marriages, and perhaps also immediate postwar marriages, should prove more than ordinarily unstable, this factor may operate in some measure to counteract the otherwise stimulating influence of war conditions upon the birth rate.

*R. L. Stevenson (1850-1894).*—The last years of Stevenson were spent in Samoa. There he felt better than he had anywhere else during his many years in search of health. Probably, he did more of his writing in sickness than out. He was beloved by his Samoans, and when he lay dying they sat sorrowing around him. Afterwards, they cleared a road up a steep mountainside to his chosen spot on the summit, and there buried the brave soldier who had so long and gallantly fought against tuberculosis.—Warner's *Calendar of Medical History*.

## TWENTY-FIVE YEARS AGO†

## EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIX, No. 3, March, 1921

EXCERPTS FROM EDITORIAL NOTES

*What Do You Get Out of the State Medical Society?*—This is directed straight at YOU, you who are a member of your county society, you who are practicing medicine as a means of making a livelihood, you who are interested in the ideal of medical service, you who have a family to support and a citizen's duty to fulfill. You pay your annual dues and you doubtless wonder what it goes for and what, after all, the county and state medical societies do to justify their existence. Many say they do nothing to justify their existence. For a moment, will you please take exact stock of whether the State society is really worth your dues and what you expect to gain by membership.

The question at the head of this column can be answered thus: You get out of the State Medical Society exactly what and in proportion to what you put into it. It affords you legal protection. It gives you an opportunity for contact with the best of your profession in this and all states. It preserves the standards of your professional practice. It is your agent in the dissemination of health propaganda and preventive medicine. Beyond these things, will you be very candid, and state exactly what else your county and state societies do for you? Will you then analyze your answer in the light of what you yourself have done for your county and state societies. You will find that they inevitably strike a balance. If your county society is not alive and worth while to every member, if the state society does not promote the activities you think it ought to promote, if either of them fall short of what YOU think they should do and be, consider well your own part in them and mend your ways. The fault lies exactly with you. The state society is a democratic institution and is governed solely by the votes of the majority. . . .

*The Need for Autopsies.*—It does not seem to be realized generally how much the progress of medical knowledge and the development of the skill of our practitioners depends upon the possibility of a thorough and yet reverent examination of the dead. . . .

The laity also never seems to realize that each case of disease is a law to itself and is in many essential ways different from each similar case. The average person has an idea that through some obscure, more or less magic process the "doctor" arrives at a *diagnosis* and that, when this wonderful feat has been accomplished, the rest is plain sailing. We ourselves are partly to blame for this impression. . . .

The laity should know that it is inconceivable that a physician should keep his judgment unimpaired without frequently having his opinions checked up at the autopsy-table. . . .

*Municipal Tuberculosis Program.*—The value to public health and economic welfare of the work of the allied (Continued from Front Advertising Section, on Page 12)

† This column, compiled by the undersigned, strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M.D.

Secretary-Treasurer

## Board Proceedings

The Board of Medical Examiners held an oral examination on Saturday and Sunday, January 19th and 20th, in the State Building, Los Angeles, at which one hundred and seventeen (117) applicants presented themselves for examination.

During the year 1945 there were one thousand nine hundred and twenty-six (1,926) applications filed for the various types of certificates issued by the Board of Medical Examiners; of this number one thousand seven hundred and four (1,704) were for physicians and surgeons certificates. The number of applications filed for written examination showed a slight increase over the previous year while the number of reciprocity applicants who based their applications on a license issued by another State, National Board Credentials, or Commissions in the United States Army, Navy, or Public Health Service showed an increase of five hundred and twenty-eight (528), or nearly twice the number filed in 1944.

The number of certificates issued in 1945, of all types, totaled one thousand four hundred and nineteen (1,419); of this number one thousand two hundred and eight were physicians and surgeons certificates. Five hundred and ninety-nine (599) were issued by reciprocity to applicants who based their applications on a license issued by some other State, ninety-eight (98) were issued on National Board Credentials, and eleven were issued on Government Credentials.

On December 31, 1945, there were 641 applications of all classes on file and awaiting final disposition in 1946.

## News

"A twelve weeks' refresher course in psychiatry and neurology will be given by the University of California Extension Division under the direction of Dr. Karl M. Bowman. The course will open Monday at the Langley Porter Clinic, San Francisco campus, University of California Medical School. The course is intended particularly for former medical members of the armed forces, who have returned or are about to return to civilian practice." (San Francisco *Call Bulletin*, January 4, 1946.)

"Sentence of 180 days in the county jail, imposed on Neil Zola Garess of La Crescenta on charges to which he pleaded guilty of practicing medicine without a license and of representing himself as a physician, was suspended by Judge Bert P. Woodard in justice court today and the defendant placed on one year's probation and ordered to pay a \$100 fine. In imposing sentence, the court ordered Garess to refrain from further practice as a physician. The charges were filed by Maynard C. Youngs for the State Medical Board. Garess is employed as a prescription clerk in a Los Angeles pharmacy." (Glendale *News-Press*, December 14, 1945.)

J. R. Dieffenbacher, a State department of public (Continued in Back Advertising Section, on Page 54)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.